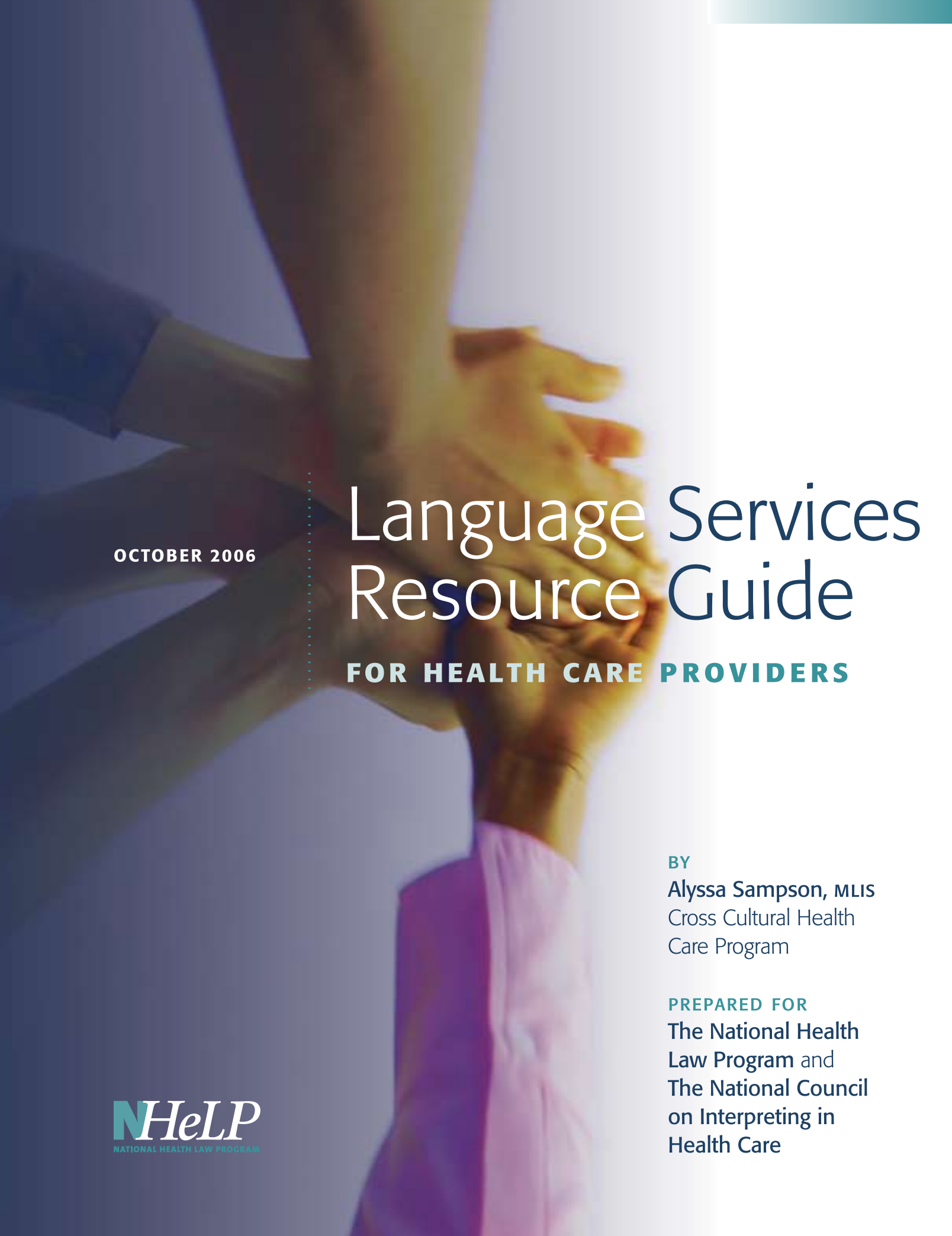

OCTOBER 2006

Language Services Resource Guide

FOR HEALTH CARE PROVIDERS

BY

Alyssa Sampson, MLIS
Cross Cultural Health Care Program

PREPARED FOR

The National Health Law Program and The National Council on Interpreting in Health Care

NHeLP
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Language Services Resource Guide for Health Care Providers

Written and Compiled by Alyssa Sampson

Cross Cultural Health Care Program

The National Health Law Program

Los Angeles, CA • Washington, DC • Chapel Hill, NC

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The Resource Guide was primarily written by Alyssa Sampson with substantial help from Maria Michalczyk, Mara Youdelman, and a review committee from the National Council on Interpreting in Health Care: Wilma Alvarado-Little, Joy Connell, and Elaine Quinn. The National Health Law Program added additional sections.

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Introduction

In 2003, the National Health Law Program convened national organizations interested in working together on language access issues. This coalition is a collaborative effort to envision and foster a health care delivery system that would better respond to the increasing diversity of our nation. The coalition joins health care providers, advocates, language services agencies, accrediting organizations, and other interested stakeholders to identify areas of consensus to improve language access for limited English proficient individuals.

The coalition developed a Statement of Principles (see Appendix A) to guide its work. The very first Principle embodies the commitment of the coalition — a recognition that the ultimate goal in the health care setting is effective communication between provider and patient. It states: "Effective communication between health care providers and patients is essential to facilitating access to care, reducing health disparities and medical errors, and assuring a patient's ability to adhere to treatment plans." Other principles address issues of funding for language services, technical assistance, workforce diversity, data collection, and quality improvement.

At the coalition's first meeting, members identified the need to develop resources to assist in identifying and providing language services. This guide, developed with input from the coalition, gathers basic information about providing language services in one document. Information includes interpreter and translator associations and agencies, training programs, assessment tools, and other materials. A searchable version is available online at **www.healthlaw.org**.

We hope that this guide will aid health care providers, administrators, interpreters, translators, and others in improving language access and improving health care for their clients and patients. As we will be updating an on-line version of this guide, if you know of other resources or information that should be included, please contact Mara Youdelman at the National Health Law Program, **youdelman@healthlaw.org** or 202-289-7661.

Contents of this Guide

Chapter 1. Assessment of Needs and Development of a Language Services Plan
This chapter gives an overview of the issues around language access. First, it provides information on the demographics of the United States and the changing face of the

limited English proficient population. It also explains concerns with relying on untrained interpreters such as family members, friends, and children in health care encounters.

Chapter 2. Assessment of Needs and Developing a Language Services Plan

This chapter offers basic steps for identifying the language services needs of a provider's client base and information about two assessment tools to help providers determine their needs (excerpts from these tools are in Appendix C and D). The chapter also includes other resources on developing language services from the Office of Minority Health, America's Health Insurance Plans, the American Medical Association, and Joint Commission Resources (an affiliate of the Joint Commission on Accreditation of Healthcare Organizations).

Chapter 3. Language Service Resource Locator

Locating language services can often be challenging. The chapter's association listing includes local, state, regional and national organizations. These associations can be valuable resources for both individual providers and health care institutions in need of language services. A directory of language service providers follows. This directory is far from comprehensive. Attempts were made to find language services in every state. To our knowledge, only programs that provide services to the public are listed, rather than those limited to in-house service. Many unique and innovative in-house language access services also exist within various hospitals and social services settings, but since their services are not accessible by non-affiliated health care providers, they are not included in these listings. However, exploring whether in-house programs exist in your local communities may provide valuable information and resources as you develop your own language services.

Chapter 4. Interpreter Training Programs Directory

A directory of health care interpreter training programs in the United States is included here, in case you seek to improve the training and education of interpreters and translators you may hire in your office or from outside sources. Dozens of programs are detailed, ranging from two-day introductory seminars to graduate degree programs. The listing is limited to programs that train students outside their own institutions, rather than in-house programs.

Chapter 5. Multilingual Tools and Resources

This chapter offers a sampling of materials available to aid in providing language services, such as sources for preexisting translated patient materials, "I-Speak" cards, bilingual dictionaries, and testing resources.

Chapter 6. Health Care Symbols

Finding one's way through a large health care provider, such as a hospital, can be especially challenging for limited English proficient individuals. Recent developments in symbols can assist providers in helping LEP individuals navigate through the system and may be especially useful for entities whose LEP clientele speak multiple languages and where multilingual signage may not be feasible for space or other reasons.

Chapter 7. Brief Guide to U.S. Department of Health & Human Services Office for Civil Rights Resources

Chapter 7 is a brief guide to the U.S. Department of Health and Human Services Office for Civil Rights, particularly the resources available through its website.

Chapter 8. Glossary of Terms

The last chapter consists of a Glossary of Interpreting and Translation Terms. The glossary draws from several sources, including the glossary found in NCIHC's *National Standards of Practice for Interpreters in Health Care*, from September 2005, the California Health Interpreters Association, and ASTM International.

Appendices

The Appendices contain additional information, including how Medicaid and the State Children's Health Insurance Program can provide reimbursement for language services, work of national organizations to raise awareness of the need for improved resources and funding for language access at the federal level, and other resources.

1 Background

Contents of this Chapter

- **BACKGROUND:** The Research on Language Services
- **BY THE NUMBERS:** The Growing Need for Language Services
- Why Using Friends and Family Members is Not Advisable

BACKGROUND:

The Research on Language Services

In a perfect world, perhaps, people would be able to communicate with each other flawlessly using a common language. In the present world, however, language services that enable accurate communication among people who otherwise would not understand each other are an essential element for providing quality care to patients with limited English proficiency (LEP). The available evidence clearly establishes how important it is for LEP individuals to be able to communicate effectively with their health care providers, and *vice versa*. Limited English proficiency among patients can result in the provision of substandard health care due to inaccurate or incomplete information.[1] Language barriers can also increase the cost of care.[2] They are a primary reason why LEP populations disproportionately underutilize less expensive and quality-enhancing preventive care.[3] In addition, an inability to comprehend the patient, mixed with a fear of liability, can lead some providers to avoid LEP patients altogether or, in the alternative, to order expensive, otherwise avoidable tests.[4]

Accurate communication ensures the correct exchange of information that allows patients to provide informed consent for treatment. Competent interpretation has also been found to avoid incorrect diagnoses and delays in care. Numerous studies have documented the problems associated with a lack of language services, including one by the United States Institute of Medicine, which stated that:

Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g. difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with

medication regimes, poor appointment attendance, and decreased satisfaction with services. (Cites omitted.)[5]

Another study, while confirming problems with informed consent, concluded that the failure to appreciate the importance of language and culture in pediatric emergencies is also associated with inadequate understanding of diagnoses and treatment by families, dissatisfaction with care, preventable morbidity and mortality, and lower quality of care, as well as with disparities in prescriptions, analgesia, test ordering, and diagnostic evaluations.[6] Research determined that asthmatic patients who did not speak the same language as their physicians were less likely to keep scheduled office appointments and more likely to use the emergency room and to miss follow up medications.[7]

Indeed, language barriers have been found to be as significant as the lack of insurance in predicting use of health services. Health care providers surveyed in four major metropolitan areas identified language difficulties as a major barrier to immigrants' access to health care and a serious threat to medical care quality. These providers also expressed concern that they could not get information to make good diagnoses and that patients might not understand prescribed treatment.[8] On the other hand, while Latino children generally have much less access to medical care than do white children, that gap becomes negligible when their parents' English-speaking skills are comparable to those of Whites.[9]

While the failure to address language barriers can lead to much harm, LEP individuals who through the use of competent language services *can* communicate effectively with their health care providers reap the benefits of accessing preventive care, understanding their diagnosis and condition, making informed decisions about treatment options, and following through with recommended treatments. This in turn leads to better health outcomes. In a survey by PALS for Health, 96 percent of those surveyed reported that the PALS interpretation service directly improved their health and well-being. Positive outcomes included a better understanding of health conditions (46 percent) and an ability to ask questions and get clearer answers (19 percent).[10] Another study found that LEP Latinos with hypertension and diabetes were significantly more likely to experience improved physical functioning, better psychological well-being, better health outcomes and less pain if their primary care physician could communicate with them effectively.[11] A comparison of LEP Spanish- and Portuguese-speaking patients with non-LEP patients found that the use of interpreters significantly increased the LEP groups' utilization of preventive services, office visits, and written prescriptions.[12]

The literature thus clearly demonstrates the benefits to be derived from competent language services. But that literature also demonstrates that the emphasis in the last sentence should be on the word "competent," and that, because health care providers depend on receiving accurate information from a patient, *ad hoc* interpretation can sometimes be as harmful as no interpretation at all. Interpretation is a learned skill. While it is true that every interpreter can speak at least two languages, it does not

follow that every person who can speak two languages is an effective interpreter. The ability of a provider to diagnose accurately a patient's condition can be jeopardized by unpracticed interpreters, including family and friends, who are prone to omissions, additions, substitutions, volunteered opinions, semantic errors, and other problematic practices.[13] *Ad hoc* interpreters may themselves be limited in their English language abilities or unfamiliar with medical terminology, and they often succumb to the temptation to act as "language brokers" who informally mediate, rather than merely interpret information.[14]

While the above problems pertain to the use of any family member, friend or other untrained person as an interpreter, additional concerns arise when the interpreter is a minor.[15] The use of minors to interpret will frequently 1) require children to take on burdens, decision-making and responsibilities beyond their years or authority, 2) cause friction and a role reversal within the family structure, 3) call on the child to convey information that is technical and educationally advanced, and 4) undermine patient confidentiality. In short, using minors to interpret in the health care context should never be the norm, but only a last resort.

Most importantly, the lack of adequately trained health care interpreters can result in an increased risk of medical errors. One recent study revealed a greatly increased incidence of interpreter errors of potential clinical consequence when untrained interpreters were used instead of those with training.[16] Subsequent research determined that while interpretation errors of potential clinical consequence occurred in 12 percent of encounters using trained interpreters, they occurred in 22 percent of encounters in which *ad hoc* interpreters were employed.[17] Remarkably, and perhaps counter-intuitively, the latter figure was higher than the percentage of encounters in which such errors occurred (20 percent) when there was no interpreter present at all. The Office of Minority Health at the U.S. Department of Health and Human Services (HHS) has specifically recognized this phenomenon and offers an explanation for why bad interpretation can be as harmful as no interpretation:

> The research . . . makes clear that the error rate of untrained 'interpreters' (including family and friends) is sufficiently high as to make their use more dangerous in some circumstances than no interpreter at all. Using untrained interpreters lends a false sense of security to both provider and client that accurate communication is actually taking place.[18]

The value of competent interpretation, both to the quality of the care offered by the provider and the health of the patient, is thus beyond dispute. However, the cost of competent language services is frequently cited as a reason why they are not always readily available to those who need them. Costs are certainly an important factor, and we as a nation must surely do more to ensure that the costs of providing language services do not compromise their availability and use.

A recent report from the Office of Management and Budget estimates that providing language services would add on average only fifty cents to the cost of a one hundred dollar health care visit.[19] An HMO-based study found that for an average cost of $2.40 per person per year language services could be provided to those who needed them. It also noted that the health plans would be able to fund the increase from savings realized in other areas.[20]

There are currently a number of innovative activities underway designed to decrease the cost of providing language services. Numerous translated materials are readily available,[21] and some hospitals and managed care plans are assembling libraries of translated forms for participating providers to use.[22] Other approaches include medical interpretation through the use of videoconferencing, remote simultaneous medical interpretation by means of wireless technology, centralized language support offices, language banks (including interpreter and translation pools) and incremental compensation programs for bilingual staff. In addition, there are an ever-increasing number of agencies and community-based organizations that provide language assistance services either on a volunteer basis or at reasonable rates.[23]

Nor is it the case that there are no resources available to help defray the cost of language services. First and foremost, some payment is available from the federal government. The Centers for Medicare & Medicaid Services within HHS has made clear that federal matching payments are available for interpretation and translation services provided to Medicaid and State Children's Health Insurance Programs applicants and enrollees (see Appendix C).[24] Activity is also underway in the private sphere, where, for example, the Alameda Alliance for Health in Oakland, CA has instituted financial incentives for providers who use trained interpreters.

Moreover, when considering the issue of costs, those associated with a failure to provide language services must also be taken into account. As noted earlier, studies demonstrate that when language barriers are not adequately addressed, more tests are ordered, creating what has been called a "language-barrier premium."[25] In addition, since LEP patients are less likely to use primary and preventive care services and more likely to use more costly emergency rooms,[26] those additional costs and strains on the system, must also be factored into any cost benefit analysis of providing language services. Finally, ineffective communication will sometimes result in substantial additional medical procedures or otherwise avoidable human suffering.

Most LEP individuals endure the consequences of ineffective communication in silence, or at least unheard, precisely because of their limited English proficiency. The goal is a world in which the tools to communicate effectively with LEP patients, and thereby provide them with quality health care, are available, adequately financed and regularly utilized. We hope that the information in this Guide can help inform the provision of language services and move us towards that goal.

BY THE NUMBERS:

The Growing Need for Language Services[27]

In 2005, according to the U. S. Census Bureau, the foreign born population of the United States numbered 35.7 million people, or 12.4 percent of the population,[28] and was increasingly dispersed throughout the country.[29] Along with its growing diversity, the nation is becoming more multilingual. Almost 52 million people speak a language other than English at home.[30] Over 12 million people speak English "not well" or "not at all", and over 23 million (8.6 percent of the population) speak English less than "very well," and for medical purposes may be considered LEP.[31] Over 29 percent of all Spanish speakers, 22 percent of Asian and Pacific Islander speakers, and more than 13 percent of Indo-European speakers speak English "not well" or "not at all."[32]

Furthermore, over 5 million households in the United States are linguistically isolated, that is, living in households where all members who are 14 years of age or older have at least some difficulty with English.[33] These numbers are certain to increase because of the changing demographics of the U.S. population. Between 1990 and 2000, for example, the Hispanic population increased by 57.9 percent.[34] (The charts and tables at the end of this document provide data for each state on the percentage of its population that has LEP and the rate of growth of this population between 1990 and 2000.)

Today, hundreds of languages are spoken in both urban and rural areas of the United States.[35] The vast majority of non-English speakers are Spanish-speaking;[36] all told, however, over 300 different languages are spoken. In Los Angeles County alone, more than 80 languages are spoken.[37] Multilingualism is spreading most rapidly beyond traditional urban areas.[38] For example, since the mid-1990s immigration to North Carolina has increased by 73 percent, the largest increase in the country.[39]

Top Ten Languages Spoken in the United States (excluding English)

Spanish	10.7 percent
Chinese	0.8 percent
French	0.6 percent
German	0.5 percent
Tagalog	0.5 percent
Italian	0.4 percent
Vietnamese	0.4 percent
Korean	0.3 percent
Polish	0.3 percent
Russian	0.3 percent

It is critical that the growing numbers of LEP residents be able to communicate with their health care providers. As complicated as it

may be for English speakers to navigate the complex health care system, the difficulties are exacerbated for LEP individuals. Yet accurate communication ensures the correct exchange of information, allows patients to provide informed consent for treatment, and avoids breaches of patient-provider confidentiality.[40] The literature provides many examples of the how the lack of language services negatively affects access to and quality of health care.[41]

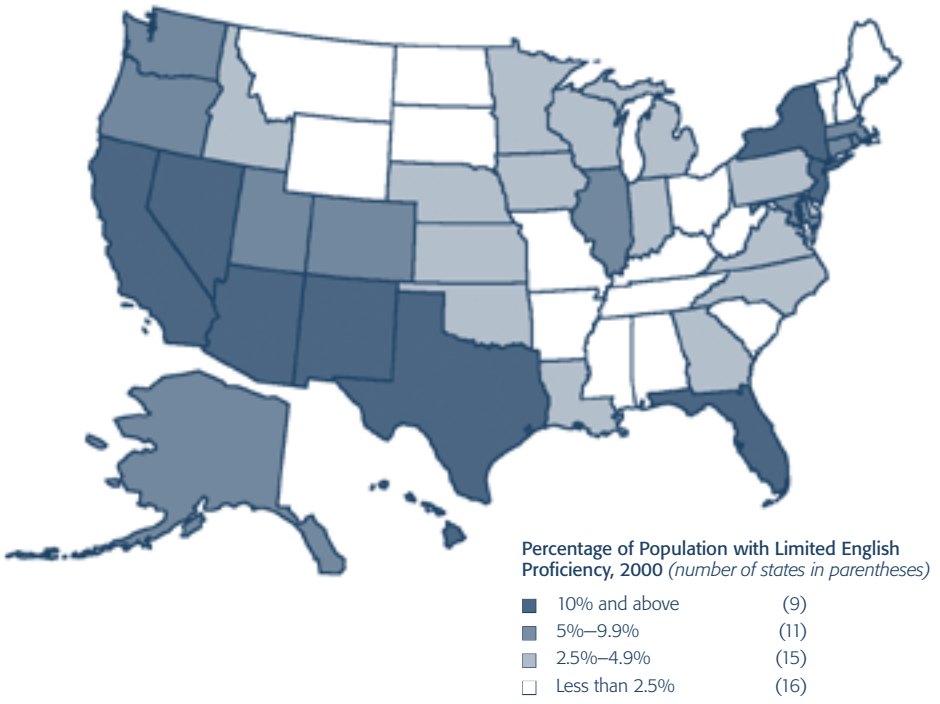
Not surprisingly, language barriers are reflected in how LEP persons perceive their health care encounters. Among Asian and Hispanic parents, for example, those who do not speak English as their primary language rated their children's health care significantly lower than did English speakers.[42] A recent survey across 16 cities found that three of four respondents needing and getting an interpreter said the facility they used was "open and accepting," compared to fewer than half (45 percent) of the respondents who needed but did not get an interpreter, and 57 percent who did not need an interpreter.[43] Unfortunately, providers are often not aware of the existence of language barriers. A March 2002 report by the Kaiser Family Foundation found that the majority of doctors believe disparities in how people are treated within the health care system "rarely" or "never" occur based on factors such as fluency in English or racial and ethnic background.[44]

In sum, the dramatic growth in the number of people who need language services is making it a business necessity for health care providers to address the issue. In addition, a number of federal and state laws and policies require providers that treat people enrolled in federally funded health care programs and activities to work to ensure meaningful access to services for people with LEP.[45] These laws are significant because health care is one of the most heavily federally-funded endeavors in the United States today, and providers that receive federal funds will inevitably see an increased demand for language services from consumers who do not speak English well or at all.

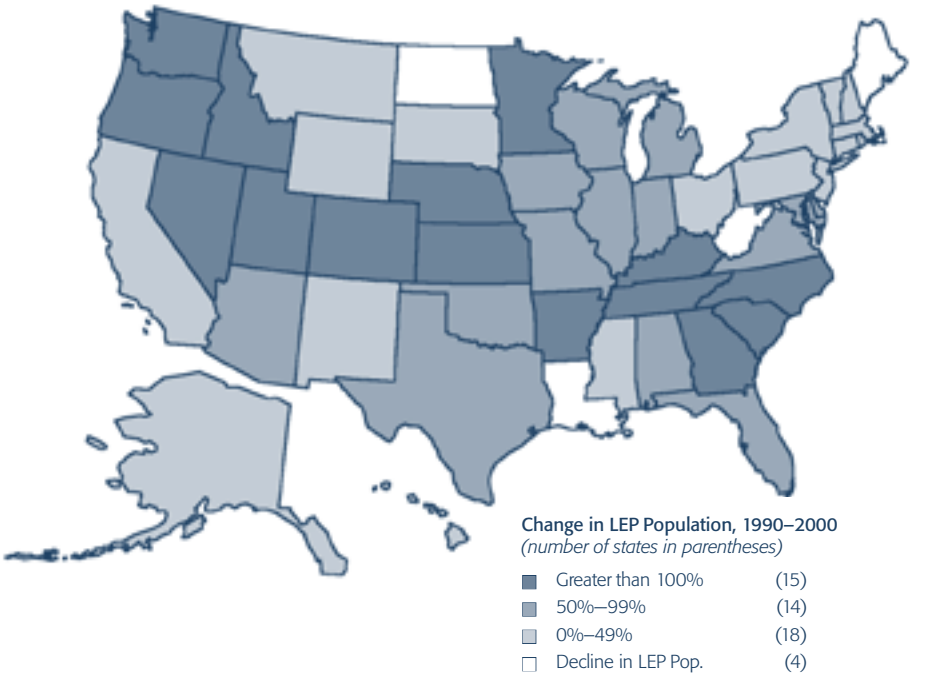
Publicly-financed managed care illustrates this point. A recent study found that Medicare+Choice plans are popular among Hispanic Medicare beneficiaries, with 51.6 percent of Hispanics enrolled in Medicare+Choice nationally.[46] Moreover, managed care has become an increasingly popular method of delivering health care to Medicaid and State Children's Health Insurance Programs beneficiaries — all but two states (AK and WY) have some form of Medicaid managed care.[47] Enrollees in these programs are disproportionately underserved racial, ethnic, and national origin minority groups. As a result, some of the most advanced policies for providing access to LEP persons are found in Medicaid managed care regulations and contracts.[48] States may also have civil rights or patients' rights statutes that address national origin discrimination.[49] These policies may prove to be models for other providers who are working to ensure access for their LEP patients.

People with Limited English Proficiency

A Look at the Numbers



Percentage of Population with Limited English Proficiency, by State, 2000



Change in LEP Population, by State, 1990–2000

Source: 1990 and 2000 Decennial Census. Limited English Proficiency refers to people age 5 and above who report speaking English less than "very well."

The proportion of a state's population with limited English proficiency (LEP) varies widely. In general, the Southwestern states plus Florida, New York and New Jersey have the greatest proportion of residents with LEP. Fully one-fifth of California's residents speak English less than "very well."

BUT...

The fastest growth in LEP populations has been in the Southeast and the West, as well as in the center of the country. Georgia, North Carolina and Nevada all saw the number of residents with limited English proficiency grow by over 200 percent between 1990 and 2000. Many of these fast-growth states had small LEP populations in the past, and their institutions may be unprepared for the change.

State	% Population with LEP, 2000	Change in LEP Population, 1990-2000
Alabama	1.5%	77.5%
Alaska	5.3%	37.2%
Arizona	11.4%	95.7%
Arkansas	2.3%	169.9%
California	20.0%	41.9%
Colorado	6.7%	143.4%
Connecticut	7.4%	27.6%
Delaware	3.9%	94.8%
District of Columbia	7.1%	31.3%
Florida	10.3%	61.7%
Georgia	4.9%	243.2%
Hawaii	12.7%	15.3%
Idaho	3.9%	108.7%
Illinois	9.1%	60.3%
Indiana	2.5%	64.9%
Iowa	2.5%	92.4%
Kansas	3.9%	103.2%
Kentucky	1.6%	100.1%
Louisiana	2.8%	-8.9%
Maine	2.0%	-13.3%
Maryland	5.0%	65.9%
Massachusetts	7.7%	31.6%
Michigan	3.2%	56.2%
Minnesota	3.6%	111.1%
Mississippi	1.4%	47.1%
Missouri	2.0%	63.7%
Montana	1.5%	10.5%
Nebraska	3.6%	159.6%
Nevada	11.2%	234.1%
New Hampshire	2.4%	13.2%
New Jersey	11.1%	43.4%
New Mexico	11.9%	26.0%
New York	13.0%	30.9%
North Carolina	4.0%	243.1%
North Dakota	1.8%	-5.7%
Ohio	2.2%	23.5%
Oklahoma	3.1%	90.8%
Oregon	5.9%	141.8%
Pennsylvania	3.2%	25.7%
Rhode Island	8.5%	26.8%
South Carolina	2.2%	117.9%
South Dakota	2.3%	31.0%
Tennessee	2.0%	137.8%
Texas	13.9%	51.2%
Utah	5.2%	158.9%
Vermont	1.6%	28.4%
Virginia	4.6%	88.4%
Washington	6.4%	112.4%
West Virginia	0.8%	-0.3%
Wisconsin	3.0%	59.6%
Wyoming	1.9%	22.7%
U.S. Total *	**8.1%**	**52.5%**

United States (#s in millions)	1990	2005
Total Population (age 5+)	230.4	268.1
LEP Population	14.0	23.1
% LEP	6.1%	8.6%

Limited English Proficiency refers to people age 5 and above who report speaking English less than "very well."

The U.S. Census Bureau provides data from the 1990 and 2000 Census at **http://factfinder.census.gov**. Census data include information on the primary language spoken at home and ability to speak English, and may be accessed at the national level or in smaller geographical groupings, including state, county, city, town, ZIP code, congressional district, and census tract, among others.

Why Relying on Family Members, Friends and Children is Not Advisable[50]

There is some reliance on saying that a patient's family members or friends can — or should — appropriately serve as interpreters. However, significant problems can arise from the use of family members, friends and particularly children, rather than trained professionals, as interpreters. Patients may suffer direct consequences because they do not fully understand a diagnosis or treatment. One study noted that interpreting errors by "ad hoc" interpreters — including family members and friends — are significantly more likely to have potential clinical consequences than interpreting provided by hospital interpreters.[51] Using trained interpreters can ensure confidentiality, prevent conflict of interest, and make sure that medical terms are interpreted correctly.

Adult family members or friends who act as interpreters often do not interpret accurately. Untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers. For example, family members and friends often do not understand the need to interpret everything the patient says, and may summarize information instead. They may also inject their own opinions and observations, or impose their own values and judgments as they interpret. Family members and friends who act as interpreters may themselves have limited English language abilities and may be completely unfamiliar with medical terminology. Furthermore many patients will not disclose sensitive or private information to family members and friends; providers may thus receive incomplete information that can prevent them from correctly diagnosing a condition. For example, if a battered woman is brought to the hospital by her batterer, who is then asked to interpret for her, the battered woman is not likely to reveal the scope and cause of her injuries.

Guidance from the federal Department of Health and Human Services' Office for Civil Rights recognizes the drawbacks of using family members and friends and encourages the use of trained interpreters whenever possible.[52]

While many problems can result from using adult family members and friends as interpreters, additional problems arise when the interpreter is a minor. Children who interpret for their LEP parents act as "language brokers" and informally mediate,

rather than merely interpret or translate information.[53] Children who act as language brokers often influence the content of the messages they translate, which in turn affects their parents' decisions. Other concerns with using children as interpreters include:

- requiring children to take on additional burdens, such as decision-making responsibilities;
- creating friction and a role reversal within the family structure, which can even lead to child abuse;
- violating beneficiary confidentiality, which can lead to inadequate services or mistakes in the provision of services; and
- causing children to miss school.

The potential for harm is exacerbated when providers use children to translate in gynecological or reproductive health settings. For example, in one case a provider performing an ultrasound on a pregnant LEP patient instructed the patient's seven-year-old daughter to tell her mother that the baby was stillborn. The provider only called a trained medical interpreter when the daughter became upset and refused to do the interpretation.

Further exemplifying the problems of using children as interpreters, a study of 150 Vietnamese- and Mexican-American women who are or had been welfare recipients in California found that more than half (53.3 percent) used their children to interpret for them. Most used their children for communicating with schools and government agencies and filling out forms. More than half of the women who used their children as interpreters identified problems with this practice. The top four problems were:

- the child interpreted incorrectly;
- the child left out information;
- the information was too technical for the child; and
- the child was unable to properly translate due to limited language skills.

Several of the Mexican-American women reported that their children sometimes answered questions without first checking with them.

These potential problems should caution health care providers from relying on family members, friends and children to interpret in clinical settings, except in emergencies. The remaining chapters of this guide provide information and resources for identifying trained, competent interpreters and translators to ensure that accurate communication occurs.

2 Assessment of Needs and Developing a Language Services Plan

Contents of this Chapter:

- Description of Language Services Assessment and Evaluation Tools
- Developing a Language Services Plan
- Other Resources

Language Services Assessment and Planning Tools

Two freely available, detailed language services assessment and planning tools are described and provided in Appendices D and E. The first is the National Council on Interpreting in Health Care's *Linguistically Appropriate Access and Services: An Evaluation and Review for Health Care Organizations,* published June 2002, available at **http://www.ncihc.org/NCIHC_PDFLinguisticallyAppropriateAccessandServicesAnEvaluationandReviewforHealthcareOrganizations.pdf.** The second is *Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance*, published by the Interagency Working Group on LEP, Civil Rights Division, Department of Justice, and available at **http://www.lep.gov/selfassesstool.htm**.

While the two tools cover some of the same territory, they are presented in different styles and have different emphases. The NCIHC tool is particularly detail oriented, asking over 150 questions, with many sub-questions. Most of these questions require a yes or no answer, while a significant number ask for additional description. The tool applies a similar set of questions to the use of agency interpreters, staff interpreters, and other modes of language services, carefully tailoring each section to the subject addressed. It also provides a glossary of terms, a bibliography, and a good deal of explanatory background information and advice on its application in a readable format. Billed as an assessment, it can provide institutions at any level of language services development with many ideas as to what to establish, strive for, or accomplish.

The U.S. government tool is less detail-oriented and more conceptual. The assessment addresses the following four factors: the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee/recipient; the frequency with which LEP individuals come in contact with the program; the nature and importance of the program, activity, or service provided by the program to people's lives; and the resources available to the grantee/recipient and costs. A significant amount of it is intended to provide a blueprint for institutions interested in designing and establishing language services by assessing preexisting services and resources and helping the institution determine what should be accomplished. In order to do this, many questions are accompanied by ideas, explanations, and suggestions.

The appendices include excerpts from each tool.

Developing a Language Services Plan

Once an assessment is completed and the needs of the provider and his/her LEP patients are identified, a provider may want to develop an implementation plan, often referred to as a "LEP Plan" or "Language Access Plan." This plan can identify how the provider will provide language services. Having a written plan can be helpful for training, administration and budgeting. According to the HHS Office for Civil Rights, there are five elements of an effective language services plan:

1. **Identifying LEP Individuals Who Need Language Assistance.**
2. **Language Assistance Measures** — a description of the types of language services available, how staff can obtain those services, how to respond to LEP callers, how to respond to LEP individuals who have in-person contact with recipient staff, and how to ensure competency of interpreters and translation services.
3. **Training Staff** — identifying staff who need to be trained regarding the recipient's LEP plan, a process for training them, and the identification of the outcomes of the training.
4. **Providing Notice to LEP Persons** — how does the the health care provider provide notice of the services that are available to the LEP persons it serves or, to the extent that a service area exists, that reside in its service area and are eligible for services.
5. **Monitoring and Updating the LEP Plan** — for example, are there any changes in current LEP populations in service area or population affected or encountered; frequency of encounters with LEP language groups; nature and importance of activities to LEP persons; availability of resources, including technological advances and sources of additional resources, and the costs imposed; whether existing assistance is meeting the needs of LEP persons; whether staff knows and understands the LEP plan and how to implement it; and whether identified sources for assistance are still available and viable.

In addition to these five elements, effective plans set clear goals and establish management accountability. Some recipients may also want to consider whether they should provide opportunities for community input and planning throughout the process.

Other Resources

The **American Medical Association** (AMA) Ethical Force Program issued a consensus report *Improving Communication—Improving Care.* The report offers guidelines and measurable expectations for health care organizations to improve communications with patients of diverse backgrounds. The report is available at **http://www.ama-assn.org/ama/pub/category/16245.html.**

Joint Commission Resources (JCR), an affiliate of the **Joint Commission on Accreditation of Healthcare Organizations**, offers *Providing Culturally and Linguistically Competent Health Care*. This book provides tips and tools for implementing or improving systems and addressing challenging issues, such as providing for non-English speaking patients; identifying who lives in the community; developing and training staff to meet patients' cultural and linguistic needs; developing and implementing a business case for cultural and linguistic competence; and providing safe, quality patient care. This book includes case studies profiling domestic and international health care organizations that have effectively improved cultural and linguistic competency to meet the needs of diverse populations. The book is available from JCR at **http://www.jcrinc.com**.

"A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations" is available from the **U.S. Office of Minority Health**. The guide is intended to help health care organizations implement effective language access services (LAS) to meet the needs of their limited English-proficient patients, and increase their access to health care. The overall purpose of this guide is to provide practical, ground-level suggestions for how health care organizations and providers can apply LAS. It is designed for hospitals and HMOs, with an eye toward addressing the needs of smaller organizations, including family practices, health clinics, and health care specialists with limited resources seeking alternative means of implementing LAS. The executive summary is available at **http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG-ExecutiveSummary.pdf**; the complete guide is available at **http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf**.

America's Health Insurance Plans (AHIP), has released a compendium of resources for health insurance plans, physicians, and health care organizations. The compendium, entitled *Communications Resources to Close the Gap,* was developed as a component of AHIP's

plan to build on its existing health disparities work, with a multifaceted initiative providing technical support for health insurance plans and other health care organizations. This is the third in a series of *Tools to Address Disparities in Health* focusing on the collection of data on race, ethnicity, and primary language; cultural competency training as a foundation to improve care; model designs for quality improvement activities to reduce disparities; and communication approaches that address the cultural diversity of America's growing racial and ethnic population. The report, along with other materials on Diversity and Cultural Competency, is available at **http://www.ahip.org/HealthAndMedicine/DiversityandCulturalCompetency**.

3 Language Services Resource Locator

Contents of this Chapter:

OVERVIEW:

Locating Sources of Interpreting and Translation Services

This chapter introduces some primary sources and starting places on the road to providing language services. Provided here are directories of language service providers and language professional associations and a description of things to consider when choosing a language company.

Perhaps the first thing to keep in mind is an understanding that translation and interpreting are separate skills and services. Within the language professions, **interpretation** is distinguished from **translation** according to whether the message is produced *orally* (or manually), which is **interpreting**, or *in writing*, which is **translation**.

Several approaches may be used to locate language services for interpreting and translation. A local, state, or regional interpreters and/or translators professional association may have a directory of available individual interpreters, translators and language companies in the area. Many of these associations' websites also offer information on language services and educational information about working with interpreters, as well as interpreter standards of practice and/or codes of ethics. The Yellow Pages of the phone book (online or in print) also lists local companies that provide language services. This chapter includes two state-by-state charts that provide the following information:

- Interpreter and Translator Associations
- Language Services Providers

The charts begin with national resources and continue with listings by state.

Considerations when Evaluating Available Language Services

There are many different ways that health care providers can offer language services. How you decide to offer language services will likely depend on factors including the number of languages of your patient population, the frequency of contact with these languages, and available local resources. Some health providers contract with language agencies or independent interpreters to provide language services. Others create their own

interpreter services departments, which they may supplement with contract interpreters and possibly telephonic interpreting for less common languages. Some providers collaborate with similar entities to share interpreter services. Some organizations have "dual-role" bilingual staff wherein interpreting is not their primary role. These staff may be receptionists, accounting, clinical staff or others who have been trained as interpreters. In some states institutions can book interpreters through agencies contracted through the state. The state may also reimburse for services of a qualified interpreter for a Medicaid patient.

A video/DVD offered by Resources in Cross-Cultural Health Care may be helpful as well. Entitled *Communicating Effectively Through an Interpreter*, it is designed to help providers in: choosing an appropriate interpreter, recognizing the signs of professional and unprofessional interpretation, working effectively with a trained interpreter, and guiding an untrained interpreter. Available at **http://xculture.org/resource/order/detail.cfm?PID=27&list=27,25,23**.

For more information, you may want to consult the following publications:

Models for the Provision of Language Access in Health Care Settings by B. Downing and C.E. Roat. Santa Rosa, CA: National Council on Interpreting in Health Care 2002, **http://www.ncihc.org/workingpapers.htm**.

Linguistically Appropriate Access and Services; An Evaluation and Review for Healthcare Organizations by C.C. Anderson. Santa Rosa; National Council on Interpreting in Health Care, 2002, **http://www.ncihc.org/workingpapers.htm** (also excerpted in Appendix C).

Providing Language Services in Small Health Care Provider Settings: Examples from the Field by M. Youdelman, J. Perkins; National Health Law Program. Washington, DC: NHeLP; New York: The Commonwealth Fund, 2005, **http://www.cmwf.org/publications/publications_show.htm?doc_id=270667**.

Providing Language Services in Health Care Settings: Examples from the Field by M. Youdelman, J. Perkins; National Health Law Program. Washington, DC: NHeLP; New York: The Commonwealth Fund, 2002, **http://www.cmwf.org/publications/publications_show.htm?doc_id=221272**.

Considerations when Evaluating Specific Language Agencies

An excellent resource on choosing and evaluating a language agency is *How to Choose and Use a Language Agency*[54] from The California Endowment. Much of the following information derives from that document.

There are a number of considerations regarding quality of interpreting when considering a language agency:

- *How does the agency recruit interpreters/translators?* An agency that does not maintain relationships with immigrant and refugee communities, professional interpreter organizations, and training programs may have difficulty filling an institution's needs.
- *How does the agency screen interpreter candidates?* Although it is unrealistic to expect all interpreters to have a college degree, they should be screened for proficiency in the languages they will be interpreting.
- *Does the agency require interpreters to have received professional training in interpreting?* While few interpreters will have degrees in interpreting, they should have received some form of professional training. The longer the training, the better, though 40 hours is common for basic training programs. Training should cover the interpreter role, ethics, modes, basic conversation skills, handling the flow of the session, intervening, and medical terminology, and should involve skill building and practice.
- *Does the agency require any continuing education of its employees/ contractors? If so, how much and what sort of proof do the employees/ contract interpreters have to offer?* Continuing education is important for active interpreters and may be offered by local interpreter associations, colleges, or other organizations.
- *How does the agency assess its interpreters' qualifications?* Unlike in the legal interpreting field, true certification programs for medical interpreters are rare. The situation varies by state, language, and company, but certification opportunities and requirements will likely increase over the next few years. For example, Language Line Services, a national for-profit telephonic interpreting agency, has an internal certification system available only to its own interpreters. The State of Washington's Department of Social and Health Services has a certification process for medical and social services interpreters involving testing for several languages and a qualification test for languages for which they have not developed testing materials. The National Association of the Deaf and the Registry for Interpreters of the Deaf (RID) have several special certificates for particular venues.
- *What code of ethics are the interpreters/ translators expected to follow?* The National Council on Interpreting in Health Care created A National Code of Ethics for Interpreters in Health Care, which can be found at **http://www.ncihc.org/NCIHC_PDF/NationalCodeofEthicsforInterpretersinHealthCare.pdf** (this code is currently under revision). Prior to the NCIHC code, numerous agencies and associations produced their own codes, the most prominent being those of the Massachusetts Medical Interpreters Association and the California Health Interpreters Association. An interpreter who has gone through any formal training should be aware of the principles contained in at least one of these codes of ethics.

- *What protocols are interpreters expected to use?* There are several issues involved, such as do the interpreters use first person interpreting (preferable), do they do pre-sessions[55] with the patient and provider, do they provide cultural information to the provider to aid in a difficult session, will they advocate if necessary, and how are interpreters expected to handle difficult situations?
- *How does the agency provide long-term quality assurance for interpretation?*
- *What mechanisms does the agency have to instruct interpreters about specific policies and procedures of your institution?*
- *Does the agency specialize in any particular industry(ies)?* For example, some agencies focus on health care/medical interpreting and their interpreters will have knowledge of specialized medical terminology.
- *Available languages.* An institution should consider its particular language needs. What languages are required? Which languages can the agency provide and how qualified are the interpreters who use those languages? Some agencies specialize in a specific language or group of languages, such as Asian languages, Spanish, Arabic, "hard to find" languages, or sign languages.
- *Back-up alliances.* Some agencies use other agencies to cover when they cannot provide an interpreter. Prospective users should make sure allied agencies have standards as high as the original agency.
- *Responsiveness.* An agency should be tracking and willing to share information about what percentage of requests it is able to fill. No agency can fill 100 percent of requests.
- *No-show rates.* An agency should also track how often its interpreters fail to show for appointments.
- *Connect times for telephonic interpreter services.* Average connect times of 45 seconds or less are preferable and competitive. Connect time should be counted from when the phone starts ringing to when an interpreter is on the line.
- *Special equipment requirements for telephonic interpreter services.* An institution may need specific equipment to work with a particular telephonic interpreter agency.
- *Disaster recovery system (for telephonic interpreter services).* What happens if the phone lines go down? Some telephonic services now have alternate systems to resort to if one technology fails. This is especially important if a telephonic service will be the institution's only interpreter service provider.
- *Switching equipment (for telephonic interpreter services).* An agency's preparedness to handle large volumes of calls will depend in part on its switching system.
- *What additional services are offered?*
- *Fees.* In-person interpreter services usually charge by the hour with a one-hour minimum, while telephonic services charge by the minute. Find out about all

the fees and variations before contracting with an agency. There may be additional fees for travel and/or waiting time. Further, are there monthly minimums or is a monthly fee credited towards usage?

- *Cancellation policies.* Most agencies charge for same-day cancellations, to pay the interpreter whose time has been reserved.
- *Learn the company's history*. There are several considerations here, such as who started the agency, what are their backgrounds, and how long the agency has been in business.
- *Industry involvement.* How is the agency involved in the development of the health interpreting field? Participation in the development of the field and awareness of the current affairs of the interpreter community suggest dedication to the field and an interest in providing the best possible service and improving the industry as a whole. A quality agency will be interested in up-to-date techniques, technology, knowledge, and ethics.
- *Key documents.* Institutions may want to ask to see a standard contract, a billing statement, and to work out details specific to the institution.
- *Get references from current clients.*
- *Request a test call from telephonic services.*

Interpreter and Translator Associations

National Associations

National Council on Interpreting in Health Care (NCIHC)

Santa Rosa, CA
F: 707-541-0437
info@NCIHC.org
http://www.ncihc.org

The National Council on Interpreting in Health Care is a multidisciplinary organization based in the United States whose mission is to promote culturally competent professional health care interpreting as a means to support equal access to health care for individuals with limited English proficiency. Its website offers listings of state interpreter associations, working papers, and A National Code of Ethics for Interpreters in Health Care and National Standards of Practice for Interpreters in Health Care.

Association of Language Companies (ALC)

Arlington, VA
T: 800-338-4155; 703-418-0391
F: 703-416-0014
info@alcus.org
http://www.alcus.org

ALC is a national trade organization representing businesses that provide translation, interpretation, and language training services. (NOTE: ALC is not solely focused on health care interpreting/translating so you may need to evaluate whether its members have the appropriate expertise to meet your needs.)

American Translators Association (ATA)

Alexandria, VA
T: (703)683-6100
F: (703)683-6122
ata@atanet.org
http://www.atanet.org

ATA offers a number of online directories, including a Directory of Interpreting and Translating Services and a Directory of Language Services Companies (see **http://www.atanet.org/bin/view.pl/18756.html**). (NOTE: ATA is not solely focused on health care interpreting/translating so you may need to evaluate whether its members have the appropriate expertise to meet your needs.)

Interpreting and Translating Organizations

This chart provides information about available interpreting and translating organizations and associations. Within the language professions, **interpretation** is distinguished from **translation** according to whether the message is produced *orally* (or manually) which is interpreting, or *in writing* which is translating. Some translation-specific organizations may not be listed, as we have prioritized interpreter organizations. National organizations are listed at the top of the chart. We have provided as much information as available. Inclusion should not be considered an endorsement, as the authors have not undertaken any evaluation of these organization's services. Personal email addresses listed here were the most up-to-date that the authors were aware of at the time of writing and are subject to change. They are publicly available elsewhere on the internet and/or were provided through communication during the making of this document.

NOTE: These organizations often do not directly provide language services but can assist with identifying available resources including individual interpreters, translators and language agencies.

KEY: I = interpreting, T = translation

Organization	I	T	City	Phone	Fax	Email	Website
NATIONAL							
American Translators Association	√	√	Alexandria, VA	703-683-6100	703-683-6122	ata@atanet.org	www.atanet.org
Association of Language Companies	√	√	Arlington, VA	800-338-4155	703-418-0391	info@alcus.org	www.alcus.org
National Council on Interpreting in Health Care	√		Santa Rosa, CA		707-541-0437	info@ncihc.org	www.ncihc.org
ALABAMA							
Interpreter Association of Alabama (IAA)	√			205-930-9173			
ALASKA							
Northwest Translators and Interpreters Society (NOTIS) (Membership in AK, ID, MT, OR, WA)	√	√	Seattle	206-382-5642		info@ notisnet.org	www.notisnet.org
ARIZONA							
Arizona Translators and Interpreters, Inc. (ATI)	√	√	Phoenix	602-546-3348		info@clic2ati.org	www.clic2ati.org
ARKANSAS							
Arkansas Medical Interpreters Society (ARMIS)	√			501-686-6556	501-686-8506		
Mid-America Chapter of ATA (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Kansas City	816-741-9441	816-741-9482	translate@ kc.rr.com	www.ata-micata.org

Organization	I	T	City	Phone	Fax	Email	Website
CALIFORNIA							
California Healthcare Interpreter Association (CHIA)	√		Sacramento	916-669-5305		chia@chia.ws	www.chia.ws
California Workers' Compensation Interpreters Association (CWCIA)	√		Laguna Hills	949-222-6612		info@cwcia.com	
Northern California Translators Association (NCTA)	√	√	Berkeley	510-845-8712	510-883-1355	ncta@ncta.org	www.ncta.org
Southern California Area Translators and Interpreters Association (SCATIA)	√	√	Los Angeles	818-725-3899	818-340-9177	info@scatia.org	www.scatia.org
COLORADO							
Colorado Association of Professional Interpreters (CAPI)	√					elopez@colorado interpreters.org	www.colorado interpreters.org
Colorado Translators Association (CTA)		√	Lafayette	720-890-7934		kathy@kd translations.com	www.cta-web.org
CONNECTICUT							
New England Translators Association (NETA) (Membership in CT, MA, ME, RI, VT)	√	√	Greensborough Bend, VT	802-533-9228		info@ netaweb.org	www.netaweb.org
DELAWARE							
Delaware Translators & Interpreters Network (DTIN)	√	√	Wilmington	302-655-5368		levinx@cs.com	
Delaware Valley Translators Association (DVTA) (Membership in southeastern PA, central and southern NJ, and DE)	√	√	West Chester, PA	215-222-0955		contactdvta@ cs.com	www.dvta.org
DISTRICT OF COLUMBIA							
National Capital Area Chapter of ATA (NCATA) (Residence in DC area not required for membership)	√	√	Washington, DC	703-255-9290	202-234-5656	johnvasquez@ msn.com	www.ncata.org
FLORIDA							
Florida Chapter of ATA (FLATA)	√	√	Miami	305-274-3434	305-437-7663	president@ atafl.org	www.atafl.org
GEORGIA							
Atlanta Association of Interpreters and Translators (AAIT)	√	√	Atlanta	770-587-4884		AAITInfo@ aait.org	www.aait.org
Medical Interpreter Network of Georgia (MING)	√		Buford	404-605-3737			www.mingweb.org
HAWAII							
Hawaii Interpreters and Translators Association (HITA)	√	√	Honolulu				home.oceanic.com/ hita

Organization	I	T	City	Phone	Fax	Email	Website
IDAHO							
Northwest Translators and Interpreters Society (NOTIS) (Membership in AK, ID, MT, OR, WA)	√	√	Seattle	206-382-5642		info@ notisnet.org	www.notisnet.org
Treasure Valley Interpreters Association	√		Boise				
ILLINOIS							
Chicago Area Translators and Interpreters Association (CHICATA)	√	√	Chicago	312-836-0961		webmaster@ chicata.org	www.chicata.org
Mid-America Chapter of ATA (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Kansas City, MO	816-741-9441	816-741-9482	translate@ kc.rr.com	www. ata-micata.org
Midwest Association of Translators and Interpreters (MATI) (Membership IL, IN, WI)	√	√	Chicago	312-427-5450	312-427-1505	moirapujols@ aol.com	www.matiata.org
INDIANA							
Midwest Association of Translators and Interpreters (MATI) (Membership in IL, IN, WI)	√	√	Chicago	312-427-5450	312-427-1505	moirapujols@ aol.com	www.matiata.org
IOWA							
Iowa Interpreters and Translators Association (IITA)	√	√	Urbandale	515-865-3873	515-278-5841	info@iitanet.org	www.iitanet.org
Mid-America Chapter of ATA (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Kansas City, MO	816-741-9441	816-741-9482	translate@ kc.rr.com	www. ata-micata.org
KANSAS							
Kansas Association of Interpreters (KAI)	√		Lenexa				kai4terps.tripod. com/
Mid-America Chapter of ATA (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Kansas City, MO	816-741-9441	816-741-9482	translate@ kc.rr.com	www. ata-micata.org
KENTUCKY							
Kentucky Translator and Interpreter Association (KTIA)	√	√	Louisville	502-636-9263		ajuric@ archlou.org	
MAINE							
Association of Maine Interpreters and Translators (AMIT)	√	√	Northern Maine	207-973-7666; 207-422-3962		hvalcarcel@ emh.org or sbecque@ acadia.net	
New England Translators Association (NETA) (Membership in CT, MA, ME, NY, RI, VT)	√	√	Greensborough Bend, VT	802-533-9228		info@ netaweb.org	www.netaweb.org

Organization	I	T	City	Phone	Fax	Email	Website
MARYLAND							
National Capital Area Chapter of ATA (NCATA) (Residence in DC area not required for membership)	√	√	Washington, DC	703-255-9290	202-234-5656	johnvasquez@msn.com	www.ncata.org
MASSACHUSETTS							
Forum on the Coordination of Interpreter Services (FOCIS) c/o Interpreter Services Baystate Medical Center	√		Springfield	413-794-2502	413-794-3208	Tim.moriarty@bhs.org	
Massachusetts Medical Interpreter Association (MMIA) (With membership outside of MA)	√		Boston	617-626-8133	617-626-8138	joy.connell@dmh.state.ma.us	www.mmia.org
New England Translators Association (NETA) (Membership in CT, MA, ME, RI, VT)	√	√	Greensborough Bend, VT	802-533-9228		info@netaweb.org	www.netaweb.org
MICHIGAN							
Michigan Translators/ Interpreters Network (MiTiN)	√	√	Novi	586-778-7304	248-344-0092	info@mitinweb.org	www.mitinweb.org
MINNESOTA							
Upper Midwest Translators and Interpreters Association (UMTIA)	√	√	Minneapolis	612-625-3096	612-624-4579		
MISSOURI							
Foreign Language Interpreters Consortium (FLIC) A consortium of Kansas Association of Interpreters (KAI) (Membership in Kansas and Missouri area)	√						http://kai4terps.tripod.com
Mid-America Chapter of ATA (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Kansas City, MO	816-741-9441	816-741-9482	translate@kc.rr.com	www.ata-micata.org
Saint Louis Translators and Interpreters Network (SLTIN)			Ballwin	314-394-5334			
MONTANA							
Northwest Translators and Interpreters Society (NOTIS) (Membership in AK, ID, MT, OR, WA)	√	√	Seattle	206-382-5642		info@notisnet.org	www.notisnet.org
NEBRASKA							
Mid-America Chapter of ATA (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Kansas City, MO	816-741-9441	816-741-9482	translate@kc.rr.com	www.ata-micata.org
Nebraska Association For Translators and Interpreters (NATI)	√	√		402-740-7152		janbonet@neonramp.com	

Organization	I	T	City	Phone	Fax	Email	Website
NEVADA							
Nevada interpreters may be interested in contacting California associations							
NEW HAMPSHIRE							
New England Translators Association (NETA) (Membership in CT, MA, ME, RI, VT)	√	√	Greensborough Bend, VT	802-533-9228		info@ netaweb.org	www.netaweb.org
New Hampshire Interpreters and Translators Organization (NHITO)	√	√	Dover	603-742-1967		innal@ comcast.net	
NEW JERSEY							
Delaware Valley Translators Association (DVTA) (Membership in southeastern PA, central and southern NJ, and DE)	√	√	West Chester	215-222-0955		contactdvta@ cs.com	www.dvta.org
NEW MEXICO							
New Mexico Translators and Interpreters Association (NMTIA)	√	√	Albuquerque	505-352-9258	505-352-9372	uweschroeter@ comcast.net	www.cybermesa. com/~nmtia
NEW YORK							
Association of Medical Interpreters of New York (AMINY)	√		Albany	773-301-6438	518-459-3443	info@ aminyweb.org	www. aminyweb.org
Multicultural Association of Medical Interpreters of Central New York (MAMI of CNY)	√			315-732-2271		cebrown@ hamilton.edu	
New York Circle of Translators (NYCT)	√	√	New York	212-334-3060		president@ nyctranslators.org	www. nyctranslators.org
NORTH CAROLINA							
Carolina Association of Translators and Interpreters (CATI)	√	√	Durham	919-577-0840		catiweb@ pobox.com	www.catiweb.org
NORTH DAKOTA							
Upper Midwest Translators and Interpreters Association may be applicable							
OHIO							
Community and Court Interpreters of the Ohio Valley (CCIO)	√		Tallmadge	330-633-8146	330-376-0133	president@ ccio.org	www.ccio.org
Northeast Ohio Translators Association (NOTA)	√	√	Solon	440-519-0161		js@ jill-sommer.com	www. ohiotranslators.org
OKLAHOMA							
Mid-America Chapter of ATA (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Kansas City, MO	816-741-9441	816-741-9482	translate@ kc.rr.com	www. ata-micata.org

Organization	I	T	City	Phone	Fax	Email	Website
OREGON							
Northwest Translators and Interpreters Society (NOTIS) (Membership in AK, ID, OR, MT, WA)	√	√	Seattle	206-382-5642		info@notisnet.org	www.notisnet.org
Oregon Interpreter Association (OIA)	√					thevegas@open.org; amorenoco@msn.org	
Associated Linguists of Oregon (Membership OR and Vancouver, WA)	√	√				alo@canvasdreams.com	Yahoo group: groups.yahoo.com/group/alo-oregon/
PENNSYLVANIA							
Delaware Valley Translators Association (DVTA) (Membership in southeastern PA, central and southern NJ, and DE)	√	√	West Chester	215-222-0955		contactdvta@cs.com	www.dvta.org
Pennsylvania Association of Medical Interpreters (PAMI)	√			215-632-9000		info@medicalinterpreters.org	
RHODE ISLAND							
Massachusetts Medical Interpreter Association (MMIA) (With membership outside of MA)	√		Boston	617-626-8133	617-626-8138	joy.connell@dmh.state.ma.us	www.mmia.org
New England Translators Association (NETA) (Membership in CT, MA, ME, NY, RI, VT)	√	√	Greensborough Bend, VT	802-533-9228		info@netaweb.org	www.netaweb.org
SOUTH CAROLINA							
Carolina Association of Translators and Interpreters (CATI)	√	√	Durham	919-577-0840		catiweb@pobox.com	www.catiweb.org
South Carolina Healthcare Interpreters Association	√			843-792-4362		robers@musc.edu	www.schia.org
SOUTH DAKOTA							
Upper Midwest Translators and Interpreters Association may be applicable							
TENNESSEE							
Tennessee Association of Professional Interpreters and Translators (TAPIT)	√	√	Nashville	615-269-9033		m_dubravka@comcast.net	www.tapit.org
TEXAS							
Austin Area Translators and Interpreters Association (AATIA)	√	√	Austin	512-707-3900		mediaz@austin.rr.com	www.aatia.org
El Paso Interpreters and Translators Association (EPITA)	√	√	El Paso	915-598-4757		mhogan@elp.rr.com	
Houston Interpreters and Translators Association (HITA)	√	√	Houston	713-202-6169			www.hitagroup.org
Metroplex Interpreters and Translators Association (MITA)	√	√	Arlington	817-417-4747			www.dfw-mita.com

Organization	I	T	City	Phone	Fax	Email	Website
UTAH							
Utah Translators and Interpreters Association (UTIA)	√	√	Salt Lake City	801-359-7811	801-359-9304	JCAlleman@aol.com	
VERMONT							
New England Translators Association (NETA) (Membership in CT, MA, ME, NY, RI, VT)	√	√	Greensborough Bend, VT	802-533-9228		info@netaweb.org	www.netaweb.org
VIRGINIA							
Mid Atlantic Interpreters Association (MAIA) (status unknown)	√						
National Capital Area Chapter of ATA (NCATA) (Residence in DC area not required for membership)	√	√	Washington, DC	703-255-9290	202-234-5656	johnvasquez@msn.com	www.ncata.org
WASHINGTON							
Northwest Translators and Interpreters Society (NOTIS) (Membership in AK, ID, MT, OR, WA). Includes interest group Society of Medical Interpreters (SOMI)	√	√	Seattle	206-382-5642		info@notisnet.org	www.notisnet.org
WEST VIRGINIA							
Interested parties in West Virginia may wish to contact associations in the neighboring states of Kentucky, Maryland, Ohio, Pennsylvania, Virginia.							
WISCONSIN							
Midwest Association of Translators and Interpreters (MATI) (Membership in IL, IN, WI)	√	√	Chicago	312-427-5450	312-427-1505	moirapujols@aol.com	www.matiata.org
WYOMING							
Interested parties in Wyoming may wish to contact associations in the neighboring states of Colorado, Idaho, Montana, Nebraska, South Dakota, Utah.							

Language Service Providers

The following directory contains both nonprofit and commercial providers of interpreter and translation services. Though all the agencies have experience providing language services in health care or related areas, inclusion does not constitute an endorsement of an agency's services, as we have not undertaken any evaluation of the providers included herein. Effort has been made to seek and list language service providers in every part of the United States, but availability of quality resources varies from place to place. The directory is far from comprehensive but should provide an idea of what is available and the types of organizations to seek. Many additional high quality services and resources exist across the United States; the Yellow Pages of the phone book (online or in print) lists local companies that provide language services. While inclusion here does not constitute an endorsement, neither does absence imply anything particular about an agency not listed.

A Note about Certification and Training

There are currently no federal health care interpreter certification standards and no consensus on a meaning of certification or adequate training for interpreters in health care. An institution or client should seek to find out what assessments an agency conducts with its interpreters and what interpreter training/education qualifications the interpreters hold.

Nonprofit Sources

Nonprofit organizations providing interpreter and translation services include state and local governmental public health departments, college and university-based programs, faith-based charities, refugee resettlement agencies, mutual assistance associations, a variety of independent community-based service organizations, and cooperative efforts between multiple partners. Innovative efforts are being executed throughout the country in which organizations are finding ways to address their communities' unique needs. In this directory we have tried to list only organizations that extend language services to outside users in the community.

Faith-based nonprofits such as Catholic Charities and Jewish Vocational Services play a large and varied role in providing services to the underserved in many

communities, and exist in every state. The level of language services provided by these organizations varies. Some have a highly skilled interpreter and translation services department that serves the community, including health care needs, while others only provide interpreters to refugees during their period of resettlement services. Several are listed in this directory, but many are not. Check local offices for information on whether they provide language services.

Refugee resettlement agencies, which help new refugees who arrive in the United States with little money and few belongings adjust to their new environment and find housing, work, food, health care and fulfillment of other basic needs, sometimes provide interpreter services. In some areas, such agencies may be the only organizations equipped to assist LEP persons in accessing health care and social services. Refugee resettlement agencies, contracted by the U.S. government, may be part of faith-based charities, a university, local or state government program, or community-based organizations.

Mutual assistance associations exist in many states and communities. They may be community-based organizations providing services and advocacy to a specific or more broadly defined clientele. When an immigrant community begins to develop in a locale, members sometimes form mutual assistance organizations to help support each other. Some provide language services ranging from a single or a few languages and English to many languages, and even offer interpreter training.

A variety of other community-based organizations are involved in providing interpreter and translation services across the United States. Some maintain language banks providing volunteer or paid interpreters and translators. Standards of training and skill vary.

Other sources of language services are collaborative projects and multipartner organizations in which stakeholders such as public health departments, hospitals, community-based organizations, faith-based charities, schools, or other organizations pool their resources to provide language services, training, advocacy, and support.

In addition to the resources mentioned above, some larger health systems — such as hospitals or managed care organizations — have in-house interpreter/translation programs but may be willing to share resources or consider partnerships to expand availability and lower costs. Hospitals that put a high priority on linguistically appropriate care may become deeply involved in their local communities, conducting or partnering on health initiatives intended to address a particular refugee, immigrant, ethnic, or underserved community's health needs.

Commercial Sources

Commercial interpreting and translation businesses exist in every state. They may provide telephonic or face-to-face interpreting, or both, as well as document translation. While many firms list language services in health and medical-related fields amongst their experience, potential clients should

investigate whether an individual company would make a good match for their need to provide culturally appropriate language services in health care settings. Determine whether the language company has provided specific training on medical and health care terminology and interpreting in clinical settings for their employees or similarly evaluated their contractors. Some commercial services specialize in medical interpreting, requiring certification where available and providing specialized in-house training. Health systems may make up the bulk of such firms' clientele. Like nonprofit sources, the number of choices and level of quality may vary significantly from place to place. Many companies can work outside their home base, especially in telephonic services and translation. Helpful considerations for choosing a language agency are described earlier in this chapter.

State and Local Interpreter and Translation Services

NOTE: email addresses included here were the most up-to-date that the authors were aware of at the time of writing but are subject to change. They are publicly available elsewhere on the internet or were provided through communication during the making of this document.

KEY: I = interpreting, T = translation

S (status) column: N = nonprofit, C = commercial, G = government, U = university or college

Organization	I	T	S	City	Phone	Fax	Email	Website
NATIONAL								
Benoit Language Services	√	√	C	Northboro, MA	800-261-5152 (toll free); 508-393-4190	508-393-4191	mail@benoitinc.com	benoitinc.com
Catholic Charities USA (national office for network, many of which provide interpreter services)			N	Alexandria	703-549-1390	703-549-1656		www.catholic charitiesinfo.org
CyraCom International, Inc.	√	√	C	Tucson, AZ	520-745-9447	520-745-9022	info@cyracom.com	www.cyracom.com
Geneva Worldwide, Inc.	√	√	C	New York, NY	212-255-8400; 877-464-3638	212-255-8409	genevaworldwide@aol.com	www.geneva worldwide.com
International Language Services, Inc	√	√	C	Minnetonka, MN	952-934-5678; 800-225-8964	952-934-4543	info@ilslanguages.com	www.ilslanguages.com
LLE, Inc.	√	√	C	Washington, DC	202-775-0444; 888-464-8553	202-785-5584	hlacy@lle-inc.com	www.lle-inc.com
The Language Doctors, Inc (TLD)	√	√	C	Washington, DC	202-544-2942	202-547-2311	info@tldinc.org	www.tldinc.org
Language Line Services	√		C	Monterey, CA	877-886-3885		info@languageline.com	www.language line.com
MAGNUS International Trade Services Corp.	√	√	C	Walnut, CA	909-595-8488	909-598-5852	jjou@magnuscorp.com	www.magnuscorp.com
NetworkOmni Multilingual Communications	√	√	C	Thousand Oaks, CA	805-379-1090	805-370-7474	omni@network omni.com	www.network omni.com
Pacific Interpreters, Inc.	√	√	C	Portland	800-311-1232; 503-445-5644	503-445-5501	sbanister@pacific interpreters.com	www.Pacific interpreters.com
ALABAMA								
Hispanic Interest Coalition of Alabama	√		N	Birmingham	205-591-5545; toll free: 866-265-4422	205-591-5743	info@hispanic interest.org	www.hispanic interest.org
ARIZONA								
HispanoAmerican Communications		√	C	Phoenix	800-380-1207; 480-824-2002	480-824-2013	iMcCue@hispano-american.com	www.hispano-american.com

Organization	I	T	S	City	Phone	Fax	Email	Website
CALIFORNIA								
Atlas Translation Service		√	C	Glendale	818-242-2400	818-242-2475	atlas@atlaspvs.com	www.atlaspvs.com
BioMedical Translations		√	C	Palo Alto	650-494-1317	650-494-1318		www.biomedical.com
Catholic Charities Diocese of San Diego	√	√	N	San Diego	619-231-2828	619-234-2272		www.ccdsd.org/index.shtml
Clark Translations	√	√	C	Exeter	866-329-4698; 626-683-0613	866-639-4771		www.clarktranslations.com
Communicaid Inc.	√	√	C	San Jose	408-287-8853; 866-249-8069	408-516-5266	info@communicaidinc.com	www.communicaidinc.com
ComNet International		√	C	Newbury Park	818-991-1277	805-498-9955	agel@comnetint.com	www.translationstogo.com
Health Outcomes Group		√	C	San Francisco	415-391-6161	415-391-6262	info@healthoutcomesgroup.com	www.healthoutcomesgroup.com
Healthy House	√		N	Merced	209-724-0102	209-724-0153		www.healthyhousemerced.org/default.aspx
Herrera Communications		√	C	Temecula	951-676-2088	951-676-2996	eherrera@herrera-communications.com	www.herrera-communications.com
IDEM Translations		√	C	Palo Alto	650-858-4336	650-858-4339		www.idemtranslations.com
I-Interpret, Inc.	√		C	Palo Alto	800-642-4336; 650-614-4714	650-614-4710	info@iinterpret.com	www.iinterpret.com
Inline Translation Services, Inc.		√	C	Glendale	818-547-4995	818-547-4013	richard@inlinela.com	www.inlinela.com
Lan Do & Associates, LLC	√	√	C	San Francisco	415-978-2788	415-978-2768	Contac_lda@ldatranslation.com	www.ldatranslation.com
Lan Do & Associates, LLC	√	√	C	Fremont	510-745-8282		Contact_lda@lan-do.com	www.ldatranslation.com/contact.html
Language Frontier, Inc.	√	√	C	Morro Bay	800-498-2997; 805-771-1940	877-687-1407	services@languagefrontier.com	www.languagefrontier.com
Lingua Solutions		√	C	Sherman Oaks	818-380-3008	818-743-7411	info@linguainc.com	www.linguainc.com
PALS for Health — Garden Grove Office	√	√	N	Garden Grove	714-530-1750	714-636-8828		www.palsforhealth.org
PALS for Health — Los Angeles Office	√	√	N	Los Angeles	213-553-1818	213-553-1822		www.palsforhealth.org
Paragon Language Services	√	√	C	Los Angeles	323-966-4655; 800-499-0299	323-651-1867	info@paragonls.com	www.paragonls.com
Richard Schneider Enterprises	√	√	C	Carmel	800-500-5808; 831-622-5808	831-622-0524	service@idioms.com	www.idioms.com
Sally Low & Associates, Inc.	√	√	C	Santa Ana	714-834-9032	714-834-9035	info@interpreterservice.com	www.interpreterservice.com
San Francisco Department of Public Health Newcomers Health Program	√		G	San Francisco	415-364-7647	415-367-7660	newcomershealth@yahoo.com	www.dph.sf.ca.us/CHPP/newcomers/newcmrs.htm
SBD Interpreting Services, Inc.		√	C	La Jolla	858-459-3134	858-459-0768	info@sbdinterpreting.com	sbdinterpreting.com

Organization	I	T	S	City	Phone	Fax	Email	Website
Tele-Interpreters	√		C	Glendale	800-811-7881	818-543-6781		www.tele interpreters.com
Vietnamese Translation Services		√	C	Westminster	714-210-4710	714-775-0945	contact@ vietnamese translations.us	www. Vietnamese Translations.us
COLORADO								
Liaison Multilingual Services, Inc.	√	√	C	Centennial	303-762-0997; 800-990-1970	303-762-0999	suzanne@ eMultilingual.com	www. eMultilingual.com
CONNECTICUT								
International Institute of Connecticut	√	√	N	Bridgeport	203-336-0141	203-339-4400		members.aol. com/iiconn/ index.htm
DISTRICT OF COLUMBIA								
Language Innovations, LLC		√	C	Washington	202-349-4180; 202-349-4181	202-349-4182	translate@ language innovations.com	www.language innovations.com
Lionbridge (fka Bowne Global Solutions)	√	√	C	Washington	202-289-4777; 800-423-6756	202-289-4677	interpinquiries@ bowneglobal.com	www.bowne global.com
See National section for more vendors located in DC								
FLORIDA								
Allslavic Translation Services		√	C	Fort Lauderdale	800-775-5504	954-741-3898	info@ slavprom.com	slavprom.com
CITI Translation Center, Inc.		√	C	Bay Harbor Islands	305-868-1746		info@ cititran.com	www. cititran.com
Florida Department of Health Refugee Health Program Interpretation Services Program	√	√	G	Tallahassee	850-245-4444 x 2315	850-413-9092		www.doh.state. fl.us/Disease_ ctrl/refugee/_ Interpretation_ Services/ISP.html
LetSpeak, Inc.	√	√	C	Fort Myers	239-274-5700; 239-574-5600	239-274-9709	letspeak@ msn.com	www. letspeak.com
Mondial Translations & Interpreting		√	C	Fort Lauderdale	954-370-1223	954-370-1228	translations@ foreign translations.com	www.foreign translations.com
Total Translations, Inc.	√	√	C	Pembroke Pines	954-441-1881; 954-731-9139	954-731-9267	atamember@ aol.com	www.total translation.com
United Nations Translators & Interpreters, Inc.	√	√	C	Orlando	407-894-6020; 877-594-6020	407-894-6693	unti@unti.com	www.unti.com
GEORGIA								
Georgia Mutual Assistance Association Consortium Community Interpreter Services	√		N	Clarkston	404-296-5400 Ext. 16	404-296-0036	bernadette@ gmaac.org	www.gmaac.org/ interpret_ program.htm
HispaniCare		√	C	Roswell	770-649-0298; 678-749-6772	770-649-0299		www. hispanicare.com
Multilingual Services Network, Inc.	√	√	C	Roswell	877-606-8676; 770-407-1556	678-623-9001	info@multi lingual-services. com	www. multilingual-services.com
HAWAII								
Babel Corporation		√	C	Honolulu	808-946-3773	808-946-3993	tmc@ babeltmc.com	www. babeltmc.com
Helping Hands Hawaii	√		N	Honolulu	808-526-9724	808-536-7237	hhh@helping handshawaii.org	www.helping handshawaii.org/ bilingual.htm

Organization	I	T	S	City	Phone	Fax	Email	Website
ILLINOIS								
Adriana Rosado & Bonewitz		√	C	Libertyville	847-680-3228	847-680-3252	adriana@rosadobonewitz.com	www.rosadobonewitz.com
Heartland Alliance Cross-Cultural Interpreting Services	√		N	Chicago	773-751-4094	773-506-9872	ccis@heartlandalliance.org	www.heartlandalliance.org/mcsc/programs/ccis.htm
International Language Services	√		C	Chicago	773-525-8590	773-525-8591	ilstranslations@sbcglobal.net	www.ilschicago.com
INDIANA								
Indy Translations, LLC	√	√	C	Indianapolis	Main: 317-924-5175 Spanish: 317-924-6501 Toll free: 800-695-8772 After hours emergency: 317-501-0858	317-924-5176	info@indytranslations.com	www.indytranslations.com
International Bureau of Translations, Inc.	√	√	C	Indianapolis	317-679-4666	317-571-1509	ibtinc@ibtworld.com	www.ibtworld.com
Pangea Lingua	√	√	C	Indianapolis	317-920-1600	317-920-1601		www.pangealingua.com
ProTranslations.com, LLC		√	C	Brownsburg	317-852-1472	317-852-4682	jim@protranslations.com	www.protranslations.com
Translations InterAmerica Inc.		√	C	Indianapolis	317-842-7357		montezuck@ameritech.net	
IOWA								
Iowa Department of Human Services Bureau of Refugee Services Interpreter Services	√		N	Des Moines	515-283-7922	515-283-9160		www.dhs.state.ia.us/refugee/interpreter/default.asp
Mercy Medical Center — North Iowa, Interpretive Services	√		N	Mason City	641-422-6018	641-422-6014	GANNETTK@mercyhealth.com	
KANSAS								
Catholic Charities, Inc. — Diocese of Wichita	√		N	Wichita	316-264-8344	316-264-834		www.wkscatholiccharities.org/home555.html
Propio Language Services, LLC	√		C	Overland Park	913-385-7260; 913-302-0042	866-231-8176	doug@Propio-LS.com	www.Propio-LS.com
KENTUCKY								
Office of International Affairs Community Language Bank	√		N	Louisville	502-574-2003		www.louisvilleky.gov/international	
The International Center —Western Kentucky Refugee Mutual Assistance Association, Inc	√	√	N	Bowling Green	270-781-8336		info@internationalcenter.ky.net	internationalcenter.ky.net/index.html
LOUISIANA								
Catholic Charities — Diocese of New Orleans	√		N	New Orleans	504-310-6909	504-523-6962		
MAINE								
Language Access for New Americans	√		N	Portland	207-874-1000, x 311	207-874-1007	dhersom@unitedwaygp.org	
RISInterpret, Catholic Charities Maine	√	√	N	Portland	207-523-2726, 800-781-8550		info@CCMaine.org	www.ccmaine.org/RISInterpret/default.htm

Organization	I	T	S	City	Phone	Fax	Email	Website
MARYLAND								
Language Connections, FIRN (Foreign-born Information and Referral Network)	√		N	Columbia	410-992-1923	410-730-0113	info@firnonline.org	www.firnonline.org
Multilingual Solutions	√	√	C	Rockville	301-424-7444	301-424-7331	laurie@mlsolutions.com	www.mlsolutions.com
MASSACHUSETTS								
American Translation Partners, Inc.	√	√	C	Boston	617-350-9988; 888-443-2376	617-350-6988	scott@americantranslationpartners.com	www.americantranslationpartners.com
Catholic Charities Community Interpreter Services	√		N	Boston	617-451-7979	617-629-5768	info@cccis.org	www.cccis.org
Central Massachusetts AHEC — Medical Interpreter Dispatch Service, Language Link Cultural and Linguistic Services, Translation Services Bureau	√	√	N G U	Worcester	508-756-6676		jlcalista@cmahec.org	www.umassmed.edu/ahec/centers/Central_MA.cfm
Cross Cultural Communication Systems, Inc.	√	√	C	Winchester	781-729-3736	781-729-1217	cccsinc@cccsorg.com	www.cccsorg.com
Global Link Language Services, Inc.	√	√	C	Boston	617-451-6655	617-451-6644	info@languagetranslate.com	www.languagetranslate.com
Intransco, Inc		√	C	Lynnfield	781-334-3123	781-334-4445	info@intransco.com	www.intransco.com
Language Connections	√	√	C	Brookline	877-731-6332; 617-731-3510	617-731-3700	translate@languageconnections.com	www.languageconnections.com
Linguistic Systems, Inc.		√	C	Cambridge	800-654-5006; 617-528-7400	617-528-7490	info@linguist.com	www.linguist.com
Medical Interpreters of the North Shore	√	√	C	Lynn	781-595-6497; 781-632-4955	781-595-0643	wandcschenck@juno.com	
Multicultural Community Services, Inc.		√	C	Springfield	413-782-2500	413-796-1955	translationser@mcsnet.org	
Multilingual Planet, LLC	√	√	C	Cambridge	617-661-6700	617-249-1545	info@multilingualplanet.com	www.multilingualplanet.com
The Translation Center, University of Massachusetts Amherst	√	√	U	Amherst	877-77U-MASS; 413-545-2203	413-577-3400	transcen@hfa.umass.edu	www.umass.edu/transcen
Visiting Nurse Association (VNA) of Cape Cod	√		N	Hyannis	508-957-7601		jbouvier@vnacapecod.org	www.vnacapecod.org/index.html
MICHIGAN								
Global Reach Languages, Inc.		√	C	Jenison	616-485-0088	616-662-2239	jcoon2@gr-languages.com	gr-languages.com
Languages International, Inc.	√	√	C	Grand Rapids	616-285-0005	616-285-0004	beverly@lang-int.com	www.lang-int.com
MINNESOTA								
Accu Trans, Inc.		√	C	Minneapolis	612-823-1231; 952-925-4384	952-925-4772		www.proz.com/pro/51070
Toward, Inc./Superior Translations		√	C	Duluth	218-727-2572; 218-340-8368	612-545-4995	towardinc@aol.com	www.superiortranslations.com

Organization	I	T	S	City	Phone	Fax	Email	Website
MISSOURI								
International Institute of St. Louis		√	N	St. Louis	314-773-9090 x 152; 24 hour answering service 314-962-7770		wildermanm@iistl.org	www.intlinst.org/services/busInterpretation.asp
International Language Center/ Brunetti Language School	√		C	Saint Louis	314-647-8888; 314-646-1000	314-647-8889	dede.brunetti@ilcworldwide.com	www.ilcworldwide.com
Jewish Vocational Services — Language Services	√		N	Kansas City	816-471-2808			www.jvskc.org/page21.html
NEBRASKA								
Alegent Health Language Access Department	√		N	Omaha	402-398-6929	402-398-6929	KBahr@alegent.org	
NEW JERSEY								
International Institute of New Jersey	√	√	N	Jersey City	201-653-3888	201-963-0252		www.iinj.org
Rina Ne'eman Hebrew Language Services, Inc.		√	C	East Brunswick	732-432-0174	732-432-0175	rina@hebrewtrans.com	www.hebrewtrans.com
Translation Plus, Inc.		√	C	Hackensack	201-487-8007	201-487-8052	info@translationplus.com	www.translationplus.com
NEW MEXICO								
Northern Navajo Medical Center	√		G	Shiprock	505-368-6001	505-368-6260		
NEW YORK								
1-800-Translate		√	C	New York	800-872-6752; 212-818-1102	888-872-6752	info@1-800-translate.com	www.1-800-translate.com
Bilingual Professional Agency, Inc.	√	√	C	Brooklyn	718-339-5800	718-339-8433	translations@comprehensivenet.com	www.comprehensivenet.com
Eriksen Translations Inc.		√	C	Brooklyn	718-802-9010	718-802-0041	vigdis@eriksenInc.com	www.eriksenInc.com
Interpreters International and Translations	√	√	C	Kew Gardens	718-544-0224	718-261-3864; 508-546-5806	mzinola@interpreters-translations.com	www.interpretersinternationalandtranslations.com
International Institute of Buffalo	√	√	N	Buffalo	716-883-1900	716-883-9529	iib@iibuff.org	www.iibuff.org
Interspeak Translations, Inc.	√	√	C	New York	212-679-4772	212-679-5084	info@interspeaktrans.com	www.interspeaktrans.com/index.htm
Interspeak Translations, Inc. Upstate New York Office	√	√	C	Kerhonkson	800-529-6522			www.interspeaktrans.com
MTS Multinational Translating Service	√	√	C	Central Islip	631-581-8956; 800-864-5069	631-224-9435	info@mtsinc.us	www.mtsinc.us
Rennert Bilingual Translations		√	C	New York	212-867-8700	212-867-7666	translations@rennert.com	www.rennert.com
The Language Lab	√		C	New York	212-697-2020	212-697-2891	info@thelanguagelab.com	www.thelanguagelab.com
NORTH CAROLINA								
Choice Translating, Inc.	√	√	C	Charlotte	704-717-0043	704-717-0046	info@choicetranslating.com	www.choicetranslating.com
CICS Language Solutions	√		C	Charlotte	704-532-7446; 888-225-6056	704-532-7429		www.CICSLanguageSolutions.com

Organization	I	T	S	City	Phone	Fax	Email	Website
OHIO								
Asian American Community Services	√		N	Columbus	614-220-4023	614-220-4024	aacs@asiancomsv.org	www.asiancomsv.org
International Institute of Akron, Inc.	√	√	N	Akron	330-376-5106 x 29	330-376-0133	translation@iiakron.org	www.iiakron.org
Affordable Language Services, Ltd.	√	√	C	Cincinnati	513-745-0888	513-793-4755	translations@zoomtown.com	www.affordablelanguageservices.com
OREGON								
Certified Languages International	√	√	C	Portland	503-525-9601	503-525-9607	bill@clilang.com	www.clilang.com
IRCO (Immigrant and Refugee Community Organization) International Language Bank	√	√	N	Portland	503-234-0068	503-233-4724	interpretation@mail.irco.org; ilbtranslation@earthlink.net	www.irco.org
viaLanguage		√	C	Portland	800-737-8481	503-243-1968		www.vialanguage.com
PENNSYLVANIA								
Nationalities Service Center	√	√	N	Philadelphia	215-893-8400 x 140	215-735-8715	mormes@nationalitiesservice.org	www.nationalitiesservice.org
RHODE ISLAND								
International Institute of Rhode Island	√	√	N	Providence	401-784-8666		mchea@iiri.org	www.iiri.org
Socio Economic Development Center For South East Asians		√	N	Providence	401-941-8422	401-467-3210		
SOUTH DAKOTA								
Lutheran Social Services of South Dakota Community Interpreter Services	√	√	N	Sioux Falls	605-339-4601	605-731-2029	tjurgen@lsssd.org	www.lsssd.org/services/refugeeinterpreter.shtml
TEXAS								
Alliance for Multicultural Community Services	√		N	Houston	713-776-4700	713-776-4700	allianceontheweb@allianceontheweb.org	www.allianceontheweb.org/index.html
Catholic Charities Diocese of Fort Worth, Inc. Translation and Interpretation	√	√	N	Fort Worth	817-534-0814		info@ccdofw.org	www.ccdofw.org/translation.html
Catholic Family Service, Inc. Interpreting	√		N	Amarillo	806-376-4571		bjohnson@catholicfamilyservice.net	www.catholicfamilyservice.org
Language Resource Bank, Office of Multicultural Health, Texas Department of State Health	√		G	Austin	512-206-4602	512-206-4723	ed.calahan@mhmr.state.tx.us	www.dshs.state.tx.us/mhprograms/LanguageResourceBank.pdf
LanguageUSA	√	√	C	Austin	512-479-8881; 888-292-3405	888-292-3405	sendto@languageusa.com	www.languageusa.com
MasterWord Services	√	√	C	Houston	281-589-0810	281-589-1104	jungo@masterword.com	
Ralph McElroy Translation Company		√	C	Austin	512-472-6753	512-476-0710	TC@mcelroytranslation.com	www.mcelroytranslation.com

Organization	I	T	S	City	Phone	Fax	Email	Website
Translangco		√	C	Houston	713-464-8474	713-464-0166	info@translangco.com	www.translangco.com
Translation Source	√	√	C	Houston	281-596-0225	281-966-1869	info@translation-source.com	www.translation-source.com
UTAH								
CommGap International Language Services	√	√	C	Salt Lake City	801-944-4049	801-944-4046	info@commgap.com	www.commgap.com
Health Access Project	√		N	Salt Lake City	801-412-3980			
Linguistica International	√	√	C	Salt Lake City	801-842-2333	801-908-0220	smorales@linguisticainternational.com	www.linguisticainternational.com
U.S. Translation Company	√		C	South Ogden	801-393-5300; 801-393-0730	801-393-5500	david@ustranslation.com	www.ustranslation.com
VIRGINIA								
International Language Services, L.L.C.	√		C	Alexandria	703-721-0457	703-721-0482	ils@ilsmultilingual.com	www.ilsmultilingual.com
Northern Virginia AHEC	√	√	G	Alexandria	703-549-7060	703-549-7002	nnawab@nvahec.org	www.nvahec.org
Word For Word, Inc	√	√	C	Virginia Beach	757-557-0131	757-557-0186		www.wordforwordinc.com
WASHINGTON								
Academy of Languages Translation & Interpretation Services	√	√	C	Seattle	206-521-8601	206-521-8605	translate@aolti.com	www.aolti.com
Dynamic Language Center	√	√	C	Seattle	206-244-6709	206-243-3795	dynamic@dlc-usa.com	www.dlc-usa.com
Foreign Language Specialists, Inc.	√	√	C	Issaquah	425-369-3096; 206-261-7769	425-369-3098	president@flsincorp.net	www.flsincorp.net
Language Assistance Bureau	√	√	C	Spokane	509-448-7228			
Northwest Interpreters, Inc.	√	√	C	Vancouver	360-566-0492		vic@nwiservices.com	www.nwiservices.com
Refugee and Immigrant Service Center (RISC)	√		N	Olympia	360-754-5759	360-705-4398	risc@refugeeimmigrant.org	www.refugeeimmigrant.org
WISCONSIN								
Allegro Translations	√	√	C	Madison	800-538-5408; 608-233-3208	608-233-3511	info@allegro-translations.com	www.allegro-translations.com
The Geo Group	√	√	C	Madison	800-993-2262; 608-230-1000	608-230-1010	xlate.wi@thegeogroup.com	www.thegeogroup.com
Iverson Language Associates, Inc.		√	C	Milwaukee	800-261-1144; 414-271-1144	414-271-0144		www.iversonlang.com
Sajan, Inc.		√	C	River Falls	715-426-9505	715-426-0105	info@sajan.com	www.sajan.com
WEST VIRGINIA								
Center for Community Assistance	√	√	N	Martinsburg	304-263-3455; 304-754-4702	304-263-9004	Paragon834@aol.com	

4 Interpreter Training Program Directory

Contents of this Chapter:

Interpreter Training Program Directory

The chart on the following pages lists organizations that provide a variety of interpreter training programs, ranging from three-day beginning interpreter trainings to graduate-level university programs. The chart only includes programs that offer trainings to the general public. Programs that offer training only to their staff are not included. Programs are arranged according to state.

These training programs may be useful to health care providers in different ways. If a health care provider has bilingual staff (or plans to hire them), the provider may want to require training to ensure staff is competent to provide interpretation and/or translation. If a health care provider is seeking an interpreter/translator, either to hire as staff or as an independent contractor, individuals who have completed these training programs may be better suited to meet the needs of LEP clients.

There are currently no federal health care interpreter or translation certification standards and no consensus on a meaning of certification or adequate training for interpreters in health care. While some programs provide a certificate of completion, a certificate of attendance, or an undergraduate certificate, this is not to be understood as certification. "Certificate program," for example, does not equal certification.

Training Programs

This chart provides information about available training programs and includes as much information as available. Inclusion should not be considered an endorsement, as the authors have not undertaken any evaluation of these programs.

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
NATIONAL					
Cross Cultural Health Care Program **T:** 206-860-0329 **F:** 206-860-0334 **Email:** training@xculture.org **Web:** www.xculture.org	**Title:** ***Bridging the Gap Medical Interpreter Training*** **Length:** 40 hours **Tuition:** by arrangement **Title:** ***Bridging the Gap Training of Trainers*** **Length:** 40 hours **Tuition:** by arrangement	Medical interpreting	Fluency in English and at least one other language	Varied	**Institution type:** CCHCP will hold trainings throughout the country by special arrangement
ALABAMA					
En Español Birmingham **T:** 205-822-3848 **Web:** www.hablamosjuntos.org/demonstration_sites/grantee_profiles/default.alliance.asp		Medical interpreter training and other approaches		Spanish/English	
ARKANSAS					
University of Arkansas for Medical Sciences — Medical Interpreter Training Program Little Rock **T:** 501-686-6556 **F:** 510-686-8506 **Email:** levitskayaangelinag@uams.edu **Web:** http://rpweb.uams.edu/MedicalInterpreter/	**Title:** ***Bridging the Gap Length: 40 hours*** **Tuition:** Free for UAMS employees, $200 for all others. $55 materials fee for all participants.	Medical interpreting	Fluency in English and at least one other language, two years of college or similar education	English and any other language	**Recognition:** Certificate of completion **Institution type:** Public university

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
ARIZONA					
National Center for Interpretation — University of Arizona Tucson **T:** 520-621-3615 or 520-624-3153 **F:** 520-624-8130 **Email:** ncitrp@u.arizona.edu **Web:** http://nci.arizona.edu/	**Title:** ***Intensive Workshop for Interpreters of Medical Services*** **Title:** ***Medical Interpreter Training Institute*** **Length:** Some sessions 3 days, others 6 **Tuition:** $495 for 3-day sessions, $895 for 6-day session **Title:** ***Interpreter Pass 4*** **Length:** 3 days **Tuition:** $550 **Title:** ***Interpreter Pass 5*** **Length:** 3 days plus Competency Examination **Tuition:** $1,095 **Title:** ***Medical Interpreter Competency Examination*** Tuition: $225 per individual	Medical interpreting, consecutive, sight, and simultaneous Test	For medical interpreters who want to increase their knowledge of medical interpretation Can be conducted at any of the National Center's Medical Interpreter Training Institutes; at your site; or on-site, independent of training	Spanish-English	**Recognition:** There is no standard certification in the U.S. for medical interpreters. This test allows employers to assess an interpreter's ability
Phoenix Children's Hospital Phoenix **Email:** brayes@phoenixchildrens.com **Web:** www.hispanichealth.arizona.edu/Medical%20Interpreters%20Program.doc	**Title:** ***Spanish Bilingual Assistant*** **Length:** 60 hours Tuition: $345		Bilingual speakers of English and Spanish	Spanish and English	**Additional information:** 4 credit hours through Estrella Mountain Community College
CALIFORNIA					
Asian Health Services — Language and Cultural Access Program Oakland **T:** 510-986-1153 **F:** 510-986-1068 **Email:** lokahara@ahschc.org **Web:** www.ahschc.org/	**Course or program title:** ***Connecting Worlds*** **Length:** 40 hours **Tuition:** 0–$600, depending on how each class is funded	Medical interpreting	Trains staff and external groups	Each class usually limited to no more than five language groups	**Recognition:** Letter of participation, letter indicating result of testing **Additional information:** Offers limited training-of-trainers program
California State University, Los Angeles — Division of Extended Education Los Angeles **T:** 323-343-4900 **F:** 323-343-4954 **Contact:** Iris Fiorito **Email:** ifiorito@cslanet.calstatela.edu **Web:** www.calstatela.edu/exed/certificate/legaltrans.htm	**Title:** ***Legal Interpretation and Translation — English/Spanish — Spanish/English*** Length: 3 Units each for the two medical classes	Medical interpreting and translation	Extended education students in the school's legal interpreting program	English and Spanish	**Recognition:** Part of a certificate program **Additional information:** Two medical interpreting and translation classes within a Spanish/English legal interpreting and translation program

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
California State University, Northridge Northridge **T:** 866-873-6439 **F:** 818-677-5088 **Email:** exl@csun.edu **Web:** tsengcollege.csun.edu/healthcare.html	**Title:** ***Healthcare Interpretation and Translation Series, The Roland Tseng College of Extended Learning*** **Length:** Multiple classes with various CEU values	Health care interpreting and translation	Bilingual speaker with an interest in helping individuals in a health care setting, persons who wish to pass the California State Certification for Medical Interpreting	Class can be taught in Spanish, Arabic, Japanese, Chinese, French, German, Russian, Mandarin, Italian, Farsi, Greek, Thai, Korean, and English as a Second Language	**Recognition:** CEUs
Catholic Charities Diocese of San Diego Language Bank San Diego **T:** 619-231-2828 **F:** 619-234-2272 **Web:** www.ccdsd.org/refusdlb.html	**Length:** 40 hours	Medical interpreting	Completed by all Catholic Charities San Diego Diocese language bank interpreters	English and any other language	**Recognition:** Eligibility to work for the Language Bank
City College of San Francisco San Francisco **T:** 415-452-5158 **Web:** www.ccsf.edu/Services/Vocational_Education/health/healthcareinterpreter.html	**Title:** ***Health Care Interpreter*** **Length:** 286 hours total for first three classes including 96 hours field experience; 9 credits for prerequisite classes	Health care interpreting	Bilingual, bicultural persons	Must be bilingual, bicultural, and absolutely fluent in both English and a language of service	**Recognition:** Non-credit certificate program **Additional information:** 3 anatomy, physiology, and health terminology classes recommended prior (9 units)
Cross Cultural Health Care Program Santa Rosa **T:** 707-541-0385 **F:** 707-541-0437 **Email:** julieburns7@earthlink.com **Web:** www.xculture.org	**Title: Bridging the Gap (BTG); BTG Training of Trainers (TOT)** **Length:** 40 hours for Bridging the Gap medical interpreter training; 40 hours for BTG Training of Trainers; held several times per year **Tuition:** $750 for BTG; $1450 TOT	Medical interpreting; medical interpreting training of trainers. Occasional special programs such as interpreting in trauma	CCHCP holds open-enrollment BTG courses for the general public; agencies CCHCP licenses to train may only train their own personnel	Students must be bilingual in English and a second language	**Recognition:** Certificate of Completion **Additional information:** Originator of the "Bridging the Gap" training which is now licensed to numerous organizations. CCHCP holds trainings in Seattle, Washington; Santa Rosa, CA; and other locations throughout the United States as arranged
Healthy House Merced **T:** 209-724-0102 **F:** 209-724-0153 **Contact:** Tatiana VizcaRno-Stewart **Email:** tatiana@healthyhousemerced.org **Web:** www.healthyhousemerced.org	**Title:** ***Connecting Worlds, Central Valley Version*** **Length:** 40 hours. Also a 24-hour training-of-trainers. **Tuition:** $1,200 per participant at your location (California only)	Health care interpreting	Individuals who currently interpret in health care settings or those who desire to enter the field of health care interpreting	Spanish, Hmong, Lao, and English	**Additional information:** Limited to 20 participants; can be tailored to meet the needs of organizations
ISI North Hollywood **T:** 818-753-9181 **F:** 818-753-9617 **Contact:** George Rimalower **Email:** grimalower@isitrans.com **Web:** www.isitrans.com/serv_commtodos.htm	**Title:** ***ITAP (Interpreter Training and Assessment Program)*** **Length:** 20 hours **Tuition:** Approximately $340 per participant	Medical interpreting		Any language	**Recognition:** Certificate of Achievement **Additional information:** program is modular and can be adapted to specific health care disciplines

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
Monterey Institute of International Studies Monterey **Email:** gsti@miis.edu **Web:** http://www.miis.edu/gsti-about-dean.html	**Title:** ***Graduate School of Translation & Interpretation***	Medical interpreting and translation; general interpreting and translation	Graduate students and working interpreters	Any language	**Recognition:** college credit **Additional information:** The school offers both graduate programs in interpreting and translating and short non-matriculated student courses on interpreting and translation in specific settings
Mt. San Antonio College Walnut **T:** 909-594-5611 x5241 **Contact:** Donna Burns **Web:** http://rhorc.mtsac.edu/Health%20Programs/Health_Interpret.htm	**Title:** ***Certificate Program for the Health Care Interpreter*** **Length:** 540 hours/course can be completed part-time in 10 months/8 classes	Health care interpreting	Adult students, bilingual and bicultural students, international health workers		**Recognition:** Certificate program
National Hispanic University San Jose **T:** 408-273-2765 **Contact:** George Guim **Email:** gguim@nhu.edu **Web:** www.nhu.edu/academic_departments/ti/index.htm	**Title:** ***Bilingual Medical Interpretation Program (Spanish & English)*** **Length:** 21 units	Program combines theoretical and applied course work in the fields of business, technology, medical and legal translation and interpreting.	Spanish/English bilingual students	Spanish and English	**Recognition:** Certificate program
PALS for Health Los Angeles **T:** 213-553-1818 **F:** 213-553-1822 **Email:** susanc@palsforhealth.org **Web:** www.palsforhealth.org/	**Title:** ***Connecting Worlds*** **Length:** 48 hours **Tuition:** Please contact PALS for Health	Health care and community interpreting	Bilingual persons who serve as interpreters at health care facilities and community based organizations in Southern California	Multilingual	**Recognition:** Certificate of Completion or Certificate of Attendance **Additional information:** Proficiency test required. Please contact for requirements
Santa Barbara City College, Continuing Education Santa Barbara **T:** 805-687-0812 x258 **F:** 805-569-5457 **Email:** brownm@sbcc.edu	**Title:** ***Health Care Interpreter Training*** **Length:** 40 hours. 36 contact hours **Tuition:** No tuition. $20 materials fee	Medical interpreting	Bilingual staff who are called upon to interpret for LEP patients in health care settings and/or other bilingual individuals interested in learning the basics of medical interpreting	English and Spanish	**Recognition:** Non-credit Continuing Education Award of Completion. CEUs available for RN/LVN, CAN, MFT/LCSW
Sierra Sky Interpreting and Translation Swall Meadows **Email:** kallen@qnet.com **Web:** www.teamtranslation.com	**Title:** ***Connecting Worlds*** **Length:** 40-hour beginning curriculum, 5 days **Tuition:** $200–$300 per participant; limited availability of single day session for $40	Medical/health care interpreting primarily, with accomodations made for social service/educational interpreting depending on the participants; often includes a focus on dual-role issues since so few participants are dedicated interpreters	Beginning interpreters and bilingual health care workers and providers	Varies with participant make-up	**Recognition:** CEUs for health care professional (when appropriate), usually provided by the hospital contracting the training **Additional information:** Located in rural area. Willing to travel

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
Southern California School of Interpretation Santa Fe Springs **T:** 562-906-9787 **F:** 562-906-9780 **Email:** scsisfesprings@verizon.net **Web:** www.interpreting.com/	**Title:** ***Medical Interpreter Program*** **Length:** 3 classes, 38.5 hours each, 3.5 credits each **Tuition:** $495; $453; $415 respectively for each class	Introduction to Medical Interpretation I and II; Sight Translation for Medical Interpreters	Spanish and English fluent bilingual individuals	Spanish and English	**Recognition:** College credit **Additional information:** Other interpreting classes available
Vista Community Clinic Vista **T:** 760-407-1220 **F:** 760-407-2702 **Web:** www.vistacommunityclinic.org	**Title:** ***Connecting Worlds*** **Length:** 40 hours **Tuition:** $500 per person	Health care interpreting	For health and social service support staff who serve Latino clients with limited English proficiency	Spanish and English	**Recognition:** Certificate of participation
FLORIDA					
Florida Department of Health Refugee Health Program Tallahassee **T:** 850-245-4444 x2315 **Web:** www.doh.state.fl.us/Disease_ctrl/refugee/Interpretation_Services/ISP.html	**Title:** ***Interpreter Training Program*** **Length:** 24.5 hours	Medical interpreting	Persons interested in becoming medical interpreters	English and any other language	**Additional information:** Training standards are based on the Massachusetts Medical Interpreter Association (MMIA) Standards of Practice, Judicial Council of California (JCC) Professional Ethics and the Role of the Court Interpreter. Advanced interpreter training is being developed
Gulfcoast South AHEC, Inc. / University of South Florida Health Education Training Center Sarasota **Email:** eapostol@hsc.usf.edu **Web:** www.gsahec.org/html/GSAHEC/Continuing_Education/Medical%20Interpreting.htm	**Title:** ***Medical Interpreting*** **Length:** 10–15 hours	Medical interpreting	Offered in Charlotte, DeSoto, Manatee and Sarasota counties. Appropriate for bilingual persons who interpret in a health care setting or are interested in becoming interpreters	English and any other language	A one hour presentation on the federal guidelines requiring the provision of medical interpreters for persons with Limited English Proficiency (LEP) is also offered for providers and administrators who want to learn more about the topic
IOWA					
Mercy Medical Center Des Moines Des Moines	**Title:** ***Basic Interpreter Training*** **Length:** 16 hours **Tuition:** Free	Medical interpreting	Bilingual people in the community		
Mercy Medical Center North Iowa Mason City **T:** 641-422-6018 **F:** 641-422-6014 **Email:** GANNETTK@mercyhealth.com	**Title:** ***Basic Interpreter Training*** Length: 20 hours Tuition: Free	Medical interpreting	Bilingual people in the community	Course taught in English. Most students have been Spanish interpreters, but interpreters of other languages have successfully been accommodated	**Recognition:** Certificate from local community college

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
ILLINOIS					
Heartland Alliance Multicultural Services Center Chicago **T:** 773-751-4092 **F:** 773-509-9872 **Email:** ccis@heartlandalliance.org **Web:** www.heartlandalliance.org/mcsc/programs/it.htm	**Title:** ***Interpreting Training*** **Length:** 40 for Medical Interpreting, 40 for Mental Health Interpreting, 60 for Medical/Mental Health Interpreting **Tuition:** Varies, one is $475, another can be reimbursed through working as an interpreter	Medical and Mental Health interpreting	Must be bilingual in English and a second language	English and any other language	**Recognition:** Certificate of Achievement
International Language Services, Inc. Chicago **T:** 773-525-8590 **F:** 773-525-8591 **Email:** kruschke@ilschicago.com **Web:** www.ilschicago.com	**Title:** ***Curriculum for Interpreting in Health Care*** **Length:** 40 hours plus 6 appointment internship with experienced mentor	Core interpreting course covering skills integration; code of ethics; medical terminology; role; culture brokering; values; advocacy; sight translation; professionalism. Internship offers specialization in rehabilitation services	Oral and written proficiency test to qualify for the course	All languages	**Recognition:** Certificate program. Oral and written proficiency test to pass course
Translators and Interpreters Practice Lab (TIP-Lab) Evanston **T:** 847-869-4889 **F:** 847-564-2182 **Email:** tip-lab@tip-lab.org **Web:** http://tip-lab.org/		Various pre-designed or customized programming including lab practice sessions, workshops abroad, distance learning, and intensive weekend workshops intended to improve interpreting and translation skills	Interpreters and translators hoping to improve a variety of skills	Multiple	
MASSACHUSETTS					
Area Health Education Center of Southeastern Massachusetts Brockton **T:** 508-583-2250 x239 **Email:** lvares@hcsm.org **Web:** www.hcsm.org/ahec/ahec.htm	**Title:** ***54-Hour Comprehensive Medical Interpreter Training*** **Length:** 54 hours; a 15 hour introductory course also offered **Tuition:** $35 materials fee	Medical interpreting	For bilingual staff who serve MassHealth members	Languages offered depend on who registers — need a minimum of 4 candidates to offer a training in a specific language	**Recognition:** Certificate and Letter of Completion
Boston Area Health Education Center Boston **T:** 617-534-3970 **F:** 617-534-5761 **Email:** bahec@bphc.org **Web:** www.bphc.org/programs/initiative.asp?i=165&p=8&b=1&d=2	**Title:** ***Medical Interpreting Program*** **Title:** ***Introductory Course*** Length: 15 hours **Title:** ***Comprehensive Course*** Length: 54 hours	Medical interpreting	Bilingual staff/ volunteers working with MassHealth providers who wish to improve their skills and increase their medical terminology	English and another language	**Recognition:** Certificate and Letter of Completion

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
Boston University Boston **T:** 617-353-4497 **Email:** cpe@bu.edu www.butrain.com/cpe/interpreter-translator-medical.asp	**Title:** ***Certificate Program for Medical Interpreters*** **Length:** Six university courses **Tuition:** $1,300 for intruduction, $825 each for four interpreting courses, $800 for internship	Medical interpreting and translation. Six courses: Introduction to Communication and Written Translation; Interpreting I; Medical Interpreting; Interpreting II; Community/ Public Service Interpreting; Interpreter Internship	Multilingual professionals who are able to fluently speak, read, and write English and Spanish or Portuguese or Mandarin	English and Spanish or Portuguese or Mandarin	**Recognition:** Certificate in medical interpreting **Additional information:** Legal interpreting and community interpreting programs also available
Bristol Community College Fall River **T:** 508-678-2811 **F:** 508-730-3254 **Web:** www.bristolcommunitycollege.edu	**Title:** ***Certificate of Achievement in Portuguese/English Community Interpreting*** **Length:** One year, full time. 27 credits	Interpreting in various settings including health care, courts, government agencies, and business	Fluency in English and Portuguese and high school/secondary school diploma required, see site or inquire for additional requirements	English and Portuguese	**Recognition:** Undergraduate Certificate
Cambridge College Cambridge **T:** 800-877-4723 **Web:** www.cambridgecollege.edu/undergraduate/show_program.cfm?ProgramIndex=72	**Title:** ***Medical Interpreter Training*** **Length:** One-year certificate program, 12 courses. **Tuition:** Normal Cambridge tuition rates for undergraduates, cost reduced for professional education option		Undergraduates and continuing education students	Students must demonstrate proficiency in one target language: Arabic, Chinese, Haitian Creole, Portuguese, Spanish, or Vietnamese. Some course work is specific to the target language/culture	**Recognition:** College credit as concentration within Human Services undergraduate program; or may be taken as professional education credits, non-college credit
Cross Cultural Communication Systems, Inc. Winchester **T:** 781-729-3736 x110 **F:** 781-729-1217 **Email:** cccsinc@cccsorg.com **Web:** www.crosscultural comsystem.com/institute.php	**Title:** ***Cross Cultural Communications Institute*** **Tuition:** $595 individual; $565 group rate/per person, two or more students registering together; groups larger than 30 contact CCCI for custom rates **Class:** ***Introduction to the Art of Medical Interpreting*** Length: 24 hours **Class:** ***The Art of Medical Interpretation: 54-Hour Comprehensive Training for Medical Interpreters*** **Length:** 54 hours **Class:** ***The Art of Medical Interpreting: 40-Hour Intensive Training for Medical Interpreters*** **Length:** 40 hours	Legal and medical interpreting	Those interested in medical interpreting, various skill levels	Target language materials and language coaches are provided for each language group represented in the class; student demographics vary per semester	**Recognition:** Certificate program, students who make the grade receive Certificates of Accomplishment; evaluation for college credit in development **Additional information:** Several other medical interpreting courses and workshops and additional related classes on working with interpreters and other subjects available
Harvard Pilgrim Health Care — Institute for Linguistic and Cultural Skills Quincy **T:** 617-509-6039 **F:** 617-509-7852 **Email:** felicita_alvarado@hphc.org **Web:** www.harvardpilgrim.org/	**Title:** ***Medical Interpreter Training*** **Length:** 48 hours **Tuition:** $457	Medical interpreting	Bilingual health care staff, bilingual individuals interested in becoming certified medical interpreters	Up to four languages offered per course based on registrations	

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
Language Link/ Central Massachusetts AHEC Worcester **T:** 508-756-6676 **Email:** nkesparza@cmahec.org **Web:** www.umassmed.edu/ahec/centers/Central_MA.cfm	**Title:** ***54-Hour Comprehensive Medical Interpreter Training*** **Length:** 54 hours plus 3-hour practicum **Tuition:** $50	Medical interpreting	Available to bilingual staff working with MassHealth providers	English and any other language	**Recognition:** Four college credits from Mount Wachusetts Community College **Additional information:** Applicants must pass a language assessment test that includes an evaluation of both oral and written proficiency in English and the target language of the interpreter
Merrimack Valley Area Health Education Center c/o Greater Lawrence Family Health Center Lawrence **T:** 978-685-4860	**Title:** ***54-Hour Comprehensive Medical Interpreter Training; Advanced Mental Health Interpreter Training Series; 24-Hour Medical Terminology Courses*** **Length:** 54 hours; 24 hours; seminars may vary				
Pioneer Valley Area Health Education Center Shrewsbury **T:** 508-856-4305 **Email:** ahec@umass.edu **Web:** www.umassmed.edu/ahec/centers/Pioneer_Valley.cfm	**Title:** ***Medical Interpreter Training*** **Length:** 20 hours	Medical interpreting			
University of Massachusetts, Amherst — Translation Center Amherst **T:** 413-545-2203 **F:** 413-545-2203 **Email:** transcen@hfa.umass.edu **Web:** www.umass.edu/transcen/medicalinterpreting.html	**Title:** ***CompLit 591M, Medical Interpreting Online*** **Length:** First week of February through May 15th every Spring semester / 3 credits **Tuition:** $770; $250 per credit plus registration fee	Online medical interpreting class in 8 units.	Requirements include an advanced knowledge of one language other than English, a general knowledge of scientific concepts, and the desire to improve interpretation skills; open to interpreters, translators, bilingual health workers, nurses, doctors, hospital administrators, therapists, social workers, and anyone interested in improving the quality of bilingual health care	The class is multilingual, with most major languages offered	**Recognition:** College credits at U Mass Amherst **Additional information:** All materials are in English so that students can work into the foreign language(s) of their choice
University of Massachusetts Medical School — Office of Community Programs, Cross Cultural Affairs Shrewsbury **T:** 508-856-3572 **Email:** lisa.morris@umassmed.edu	**Title:** ***Massachusetts Statewide AHEC Medical Interpreter Training Program*** **Tuition:** minimal materials fees vary **Class:** ***54 Hour Comprehensive Medical Interpreter Training*** **Length:** 54 hours **Class:** ***15 Hour Introductory Medical Interpreter Training*** **Length:** 15 Hours **Also:** ***Advanced series for experienced medical interpreters on different topics***	Medical interpreting	Bilingual staff/ volunteers working with MassHealth providers who wish to improve their skills and increase their knowledge of medical terminology and health care for LEP populations	English and any other language	**Recognition:** Certificate of Completion **Additional information:** Locations at regional AHEC's, hospitals, health care facilities, and other venues in Massachusetts

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
MARYLAND					
Cross-Cultural Communications Ellicott City **T:** 410-750-0365 **F:** 410-750-0332 **Email:** ccc@culturecrossroads.net **Web:** www.culturecrossroads.net	**Tuition:** For individual signup when Cross-Cultural Communications host the trainings, $450 per participant. To do it on request at another site, e.g., at hospitals and nonprofits, there will be a proposal with a flat fee that depends on various factors. Custom ½ to 1 day workshops also available **Class:** ***The Community Interpreter*** Length: 40 hours **Class:** ***Introduction to Medical and Community Interpreting*** **Length:** one day ***plus custom on-request half-day to two-day workshops***	Community interpreting covers medical, social and human services and education (largely K–12 schools); can focus exclusively on one area, such as medical interpreting	Bilingual persons interested in becoming community interpreters, especially bilingual employees who interpret as only one part of their job	Language-generic only but language coaches provided on request	**Recognition:** Certificate program. Three levels of certificate: qualified interpreter (completes the 40 hours successfully AND takes proficiency test), certificate of completion (completes 40 hours including passing the written skills test) and certificate of attendance
MINNESOTA					
University of Minnesota **T:** 612-624-4000 **F:** 612-626-4000 **Email:** info@cce.umn.edu **Web:** www.cce.umn.edu/creditcourses/pti/	**Title:** ***Program in Translation and Interpreting*** **Length:** 5–9 semesters; up to 27 or more credits	Several courses offered, two recommended curriculum options in medical interpreting	Highly proficient bilingual persons from various language communities who want to develop their knowledge and skills for professional translation and interpreting	English and another language	**Recognition:** Certificate of Interpreting with specializations in legal and health interpreting
NEBRASKA					
University of Nebraska at Kearney, Department of Modern Languages Kearney **T:** 308-865-8536 **Contact:** Dr. Eduardo González, Program Director **Email:** gonzaleze1@unk.edu **Web:** aaunk.unk.edu/catalogs/02-04cat/baspanti.htm	**Title:** ***Translation and Interpreting Certificate Program*** **Length:** Translation proper: two semesters, three hours per week, with some ten hours of extra practice, or more. Interpreting: two semesters, three hours per week, with some 10–15 hours extra practice **Title:** ***Bachelor's degree in Translation-1:*** participant must take other courses like Comparative Grammar, Conversation and Composition, etc.	General interpreting and translation program with coursework in medical interpreting	Traditional UNK students and non-matriculated students	Mainly English and Spanish, but other languages accommodated on an independent-study basis (especially French and/or Russian)	**Recognition:** B.A. Certificate in Translation-1
NEW JERSEY					
Rutgers University DEPARTMENT OF SPANISH AND PORTUGUESE New Brunswick **T:** 732-932-9323 **F:** 732-932-9837 **Contact:** Phyllis Zatlin **Email:** info@spanport.rutgers.edu **Web:** http://span-port.rutgers.edu/ugrad/trans.html	**Title:** ***Certificate of Proficiency in Spanish-English and English-Spanish Translation*** **Length:** 12 classes, 19–21 credits; includes a 1.5 credit class on medical/technical translation and a 1.5 credit class on hospital/community interpreting	General Spanish and English translation and interpreting program with classes and practicum in health care interpreting and translation	Undergraduate and graduate classes, open to Rutgers students and non-Rutgers students; M.A. option available; non-Rutgers students can take a 12-credit version plus a graduate course for non-degree graduate studies or apply as a graduate degree candidate	Spanish and English	**Recognition:** Certificate of Proficiency in Spanish-English and English-Spanish Translation **Additional information:** 3.5 or higher grade point average in program required

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
NEW YORK					
Center for Immigrant Health, NYU School of Medicine **T:** 212-263-8242 **F:** 212-263-8234 **Email:** gonzac05@med.nyu.edu **Web:** www.med.nyu.edu/cih	Group rates available **Title:** ***Introduction to Medical Interpreting*** **Length:** 48 hours **Tuition:** $800 **Content:** Medical interpreting **Title:** ***Medical Interpreter Training, Intermediate Level*** **Length:** 48 hours **Tuition:** $800 **Title:** ***Training in Remote Simultaneous Medical Interpreting*** **Length:** 60 hours **Tuition:** $1,000	 Medical interpreting Medical interpreting Medical interpreting	 Bilingual students with no interpreter training Bilingual students who have taken an introductory course or demonstrate sufficient knowledge of medical and colloquial terminology, ethics, and the functions of an interpreter Students rigorously screened for language aptitude and simultaneous interpreting potential	Individuals who speak English and any other language	**Recognition:** Program certification **Additional information:** Students receive written materials in the non-English language, including comprehensive bilingual medical glossaries; also offers provider training on working with medical interpreters. interpreter screening and evaluation, and language needs consulting
Hunter College New York **T:** 212-650-3850 **F:** 212-772-4302 **Email:** soriley@hunter.cuny.edu **Web:** ce.hunter.cuny.edu/courses/coursedetails.cfm?course_webid=1444	**Title:** ***Interpretation in Medical/Clinical Settings Training Programs*** **Tuition:** Typically $350–$450; prices agreed to on a project by project basis **Title:** ***Basic Interpreter Training*** ***Length:*** 40 hours **Title:** ***Certification in Interpretation for Health Care Employees*** **Length:** 40 hours **Title:** ***Non-Language Specific Training in Interpretation for Health Care Employees*** **Length:** 40 hours	Beginning interpreter training Beginning interpreter training Advanced interpreter training Beginning interpreter training	Continuing education students Bilingual employees and prospective interpreters Bilingual employees and prospective interpreters who have taken Basic Interpreter Training Program Bilingual employees and prospective interpreters	 Bilingual Spanish/ English only Bilingual Spanish/ English only English and a language other than Spanish	**Recognition:** Certificate program

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
OREGON					
Portland Community College Portland **T:** 503-731-6633 **F:** 503-977-4988 **Email:** cmichalc@pcc.edu **Web:** www.healthprofessionals.pcc.edu	**Title:** ***Health Care Interpreter Training Program*** **Length:** 117 continuing education units/hours	Health care interpreting, utilizing ITV teaching (Interactive television) format for some classes	Persons interested in in-depth interpreter training	Any language	**Recognition:** Official recognition document awarded upon successful completion of course work; state certification recognition pending **Additional information:** Seven required classes: Intro to health care interpreting concepts, Medical Terminology, Spanish Medical Terminology, Overview of Anatomy and Physiology, Advanced Health Care Interpreting Concepts, Healthcare Interpreter Skills Lab, Practicum/ Internship at a local health care institution
PENNSYLVANIA					
Health Federation of Philadelphia Philadelphia **T:** 215-977-8996 **Email:** cjones@healthfederation.org **Web:** www.healthfederation.org/interpreter.asp	**Title:** ***The Philadelphia Interpreter Training Program***	Health care interpreting, including problem solving, dealing with difficult situations, and how to continue professional development; assistance for organizations in developing internal protocols for using interpreters	Hospitals, clinics, and other organizations; bilingual staff and others interested in becoming medical interpreters	Training is not language specific; all interpreters from a single site may be trained together	Trainings customized for clients
RHODE ISLAND					
Community College of Rhode Island Providence **T:** 401-455-6112 **Web:** www.ccri.edu	**Title:** ***Medical Interpreter Training*** **Length:** three semesters **Tuition:** $727 first two semesters, 1/2 that for third semester field practicum	Medical Interpreting	Spanish/English bilingual students	English/Spanish to start	**Recognition:** College credit

Program	Course Information — Title, Length (credits/hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
SOUTH CAROLINA					
Greenville Technical College Greenville **T:** 864-250-8235 **Web:** http://www.gtbmc.com/	**Title:** ***Medical Interpreter Training I*** **Length:** 20 hours **Tuition:** $379. **Title:** ***Medical Interpreter Training II*** **Length:** 20 hours **Tuition:** $379. **Title:** ***Medical Interpreter Training III*** **Length:** 20 hours **Tuition:** $379.	Medical Interpreting I: Intro to interpretation, role of interpreter, legal/ethical aspects, overview of health care organization II: Language of medicine — medical terminology and interpretation, colloquial phrases, appropriate register III: Anatomy and physiology, pathology and treatment of common illnesses, case scenarios, critiques of interpretation	Health care providers and social services providers	Spanish, Vietnamese	
TEXAS					
Austin Community College Austin **T:** 512-731-5266 **F:** 512-312-1599 (home phone and fax) **Email:** mediaz@austin.rr.com	**Title:** ***Translation and Interpreting Certificate Program*** **Length (credits/hours/classes):** 7 courses, 30 contact hours each, 1 1/2 year program **Tuition:** $175 per course	Introduction to Translation and Interpreting; Basic/Intermediate/Advanced Interpreting; Basic/Intermediate/Advanced Translation		All languages welcome as long as students have a language partner in the class	**Recognition:** Certificate received after successful completion of each course.
Catholic Charities Translation and Interpreter Network Fort Worth **T:** 817-469-9348 or 817-338-0774 **Email:** infoccdofw@ccdofw.org **Web:** www.ccdofw.org/translation.html	**Title:** ***Introduction to Community Interpreting*** **Length:** 4 days **Tuition:** Call for rates	Interpreting in social service environments	Bilingual employees of Catholic Charities network providers and other service providers		
National Multicultural Interpreter Project, El Paso Community College El Paso **T:** 915-831-2432 V/TTY **F:** 915-831-2095 **Email:** marym@epcc.edu **Web:** www.epcc.edu/Community/NMIP/Welcome.html	**Tuition:** Online curriculum free; videos $20–$25	Online multicultural curriculum for interpreters for the deaf and deaf/blind	Interpreters for the deaf and deaf-blind	Curriculum in written English; addresses issues of multiple sign languages and other spoken languages	

Program	Course Information — Title, Length (credits/ hours/classes), Cost	Content	Target Population	Languages Accommodated	Additional Information
University of North Texas Health Science Center, School of Public Health Fort Worth **T:** 817-735-2401 or toll free 877-868-7741 **Email:** sph@hsc.unt.edu **Web:** www.hsc.unt.edu	Title: Háblenos de su salud	Introduction to Health Applied Linguistics; Language and Literacy in Latino Health; Sociolinguistics for Interpreting in the Health Fields; Cross-Cultural Communication and Mental Health Interpreting and Gender; Text Linguistics and Translation; Research Methods in Health Settings; Health Writing and the Development of Health Messsages; Advanced Health Interpreter Training; Thesis	Graduate students in Spanish	Spanish and English	**Recognition:** Masters of Public Health degree in Health Interpreting and Health Applied Linguistics Concentration
Vernon Regional Junior College Vernon **T:** 817-552-6291 **Contact:** Joe Johnston **Email:** jjohnston@vernoncollege.edu	**Title: *Spanish Language Interpreter***				
VIRGINIA					
Northern Virginia Area Health Education Center Alexandria **T:** 703-549-7060 **F:** 703-549-7002 **Email:** info@nvahec.org **Web:** www.nvahec.org	**Title: *Interpreting in Health and Community Settings*** **Length:** 40 hours ***Tuition:*** $575 for individuals, $675 for organizations	Medical interpreting	Each student much first pass a language proficiency test in English and a target language	Course is conducted in English for bilingual students; all languages are considered	**Recognition:** Certificate of Completion **Additional information:** Students must pass a post-test at the end of the course in order to receive the certificate
WASHINGTON					
Cross Cultural Health Care Program Seattle **T:** 206-860-0329 **F:** 206-860-0334 **Email:** training@xculture.org **Web:** www.xculture.org	**Title: *Bridging the Gap medical interpreter training; BTG Training of Trainers held in Santa Rosa, CA*** **Length:** 40 hours each **Tuition:** $500 for BTG in Seattle, $1450 for TOT in Santa Rosa, CA	Medical interpreting; medical interpreting training of trainers; occasional special programs such as interpreting in trauma	CCHCP holds open-enrollment BTG courses for the general public; agencies CCHCP licenses to train may only train their own personnel	Students must be bilingual in English and a second language	**Recognition:** Certificate of Completion **Additional information:** Originator of the "Bridging the Gap" training which is now licensed to numerous organizations; CCHCP holds trainings in Seattle, Washington; Santa Rosa, CA; and other locations throughout the United States as arranged

5 Multilingual Tools and Resources

Contents of this Chapter:

Overview

This chapter provides a sampling of materials available to aid in providing language services, such as sources for preexisting translated patient materials, "I Speak" cards, bilingual dictionaries, and testing resources. Many of these are available for free on the internet and can be customized to meet the needs of a variety of health care providers.

"I Speak" Cards/Posters

"I Speak" cards/posters are a handy tool for patients and providers for identifying a patient's language. The cards/posters features the same information printed in English and the patient's language.

The cards/posters can be as simple as saying "I Speak ____" or can add additional information about how to request an interpreter, patient's rights, and other details. Sometimes, nonprofit organizations or government agencies may distribute "I Speak" cards that patients will bring to a health care provider's office. It is thus important that staff who interact with patients are familiar with these cards. Some providers also have the cards and/or posters available in their offices to assist in identifying the language needs of patients.

The U.S. Department of Commerce, Bureau of the Census offers an Identification Flashcard written in 38 languages which can be used to identify the language spoken by an individual accessing services provided by federally assisted programs or activities. This flashcard can be posted so that LEP clients can scan the list, indicating to staff the language for which they will need an interpreter. **http://www.lep.gov/ISpeakCards2004.pdf**.

As another example, the California Civil Rights Bureau provides an "I Speak" card in Spanish, Laotian, Russian, Cambodian, Chinese, Farsi, Korean, Vietnamese, and Hmong. "I Speak" cards can be given to patients to keep on hand. It is available at **http://www.dss.cahwnet.gov/civilrights/ISpeakCard_1304.htm**. A practical feature of this card is the civil rights information in both languages, reminding the patient and providers of the patient's right to language services. For example, the Spanish card states:

(Front)

Hello, my name is _____ .

I speak limited English. I need competent language assistance in Spanish to have full and effective access to your programs.

Under Title VI of the 1964 Civil Rights Act, public agencies are obligated to provide competent language assistance to limited-English-proficient individuals. Social and health service agencies may call HHS' Office for Civil Rights at 1-800-368-1019 for more information. Food Stamp and WIC agencies may call USDA Office of Civil Rights at 1-888-271-5983. All other agencies may call U.S. Department of Justice, Civil Rights Division, at 1-888-848-5306.

(Back)

Hola, mi nombre es _____ .

Hablo muy poco inglés. Necesito ayuda en español para poder tener acceso completo y efectivo a sus programas.

Bajo el Título VI del Decreto de Derechos Civiles de 1964, las oficinas públicas están obligadas a roporcionar ayuda competente, en su propio idioma, a las personas con limitaciones en el inglés. Para más información, las oficinas de servicios sociales y de salud pueden llamar a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos (HHS) al 1-800-368-1019. Las oficinas de estampillas para comida y del Programa de Nutrición Suplemental Especial para Mujeres, Bebés y Niños (WIC) pueden llamar a la Oficina de Derechos Civiles del Departamento de Agricultura de los Estados Unidos (USDA) al 1-888-271-5983. Todas las otras oficinas pueden llamar a la División de Derechos Civiles del Departamento de Justicia de los Estados Unidos al 1-888-848-5306.

Interpreter Testing Resources

There are currently no federal health care interpreter certification standards and consensus on a meaning of certification for interpreters. The National Council on Interpreting in Health Care has both a Code of Ethics and Standards of Practice for Interpreters in Healthcare, available at **http://www.ncihc.org/sop.php**. The State of Washington's Department of Health and Social Services does provide interpreter testing for those seeking to interpret for the department and health and social service providers funded by the department. The states of Massachusetts, Oregon, and Indiana are developing certification programs. Some organizations and agencies offer testing or assessment services for health care interpreters.

Some language companies offer language testing to determine the bilingual skills of interpreters, translators, and/or bilingual staff who may sometimes be used to interpret/translate. These assessments can be helpful to identify whether individuals have sufficient fluency in both languages but often cannot assess whether a person is competent to interpret.

Some additional information on interpreter testing is available in the following resources:

Guide to initial assessment of interpreter qualifications by The National Council on Interpreting in Health Care. Santa Rosa, CA: NCIHC, 2001.
http://www.ncihc.org/workingpapers.htm

Washington State Department of Health and Human Services Certification
Office Bldg 2, 2nd Fl, Olympia, WA 98504-5820
http://www1.dshs.wa.gov/msa/ltc/

DSHS certifies social service interpreters, medical interpreters, translators, and DSHS active/potential bilingual employees, mental health licensed agency personnel. Testing and certification are currently available in Spanish, Russian, Vietnamese, Mandarin Chinese, Cantonese Chinese, Korean, Cambodian, and Laotian. "Qualification" or "screening" is available in most other languages (screening test). The informal authority of DSHS' program extends beyond DSHS services in that its certification/qualification has become highly desirable for medical interpreter employment in Washington State.

Multilingual Health Resources and Translated Health Promotion Materials

This section provides a sample listing of sources for preexisting translated health materials.

The Massachusetts Department of Health Office of Minority Health's document *Best Practice Recommendations for Hospital-Based Interpreter Services* provides the following introduction on the definition and characteristics of quality translation:

> *Translation is often confused with interpretation. It is important to understand that these are different activities requiring separate skills sets. Translation is the conversion of written text from one language into another, while interpretation involves the spoken word. Properly translated written materials can be critical to ensuring effective communication in the medical settings such as in the case of obtaining informed consent, establishing advanced directives, and issuing discharge instructions and prescriptions.*
>
> *Clearly identifying the target audience is the first step and most important step in developing an effective translation. This decision involves determining the literacy level, the cultural concepts, and the regional language variations that are to be incorporated into the translation.*
>
> *The goals of translation include assuring reliability, completeness, accuracy, and cultural appropriateness. Reliability is achieved when nothing is omitted and nothing is added to the original message. Accuracy is achieved when a text is free of spelling and grammatical errors. Cultural appropriateness is achieved when the message of the text is meaningful and appropriate for the target culture.*[56]

There are far more resources available than those listed here. We have tried to include sites with a variety of resources from recognized sources, but we have not evaluated the quality of any of the translations. Evaluating preexisting translated materials for quality can be difficult to impossible depending on the circumstances. In many cases, the health worker providing the patient with materials will be unfamiliar with the patient's language and unable to directly assess quality. At the very least, consider the source. Can you discern who translated and produced the material? Does it seem reputable? Does it come from an agency dedicated to providing quality care to LEP people, or a reputable translation company accustomed to doing culturally appropriate medical translations?

Types of resources listed in this section include:

- General search engines and directories
- Site with multilingual health materials on multiple topics
- Mental health sites
- Sites concentrating on specific topics such as cancer, health issues of specific populations, and sites with translations in only one language other than English

Search Engines

Many internet search engines have options for searching sites in specific languages. Look around on the search engine's home page for options such as "language" or "preferences."

Google.com
The premier internet search engine. At **http://www.google.com/preferences** the user can choose from amongst 35 languages. Alternate fonts may be necessary for some languages.

Yahoo.com
http://www.yahoo.com/
Scroll down Yahoo's home page to find Yahoo in other countries. As of July 2005, about 30 countries were featured and U.S. Yahoo was available in Russian, Spanish, and Chinese in addition to English. Clicking on these will bring you to a Yahoo menu that includes health sites, or to a page saying you need to be able to view a particular writing system in order to use the site. This, of course, will be true of most sites that use something other than the Roman alphabet.

Other Sites

General Health—Multiple Languages, Multiple Subjects

The 24 Languages Project
http://medstat.med.utah.edu/library/refdesk/24lang.html
Over 200 health brochures in 24 languages from the Utah Department of Health and the University of Utah.

Diversity Health Institute Clearinghouse
(Australia)
http://203.32.142.106/clearinghouse
Health education resources translated into multiple languages (click on Resources from the left-side menu).

Ethnic Health Resource List
Utah Department of Health
http://hlunix.hl.state.ut.us/hrm/ethnic/resource.html
Contact information for sources of hard copy health promotion material in Cambodian, Chinese, English, Hmong, Korean, Laotian, Russian, Spanish, Thai, Tongan, and Vietnamese. This list has been around for some time and some materials may be out of production, but the selection is impressive.

Ethnomed
http://ethnomed.org
Ethnomed, a site produced by Harborview Medical Center in Seattle, frequently adds patient education materials in various languages. It is particularly strong on Southeast Asian and East African languages and health topics especially relevant to these populations, and provides health-issue-specific cultural information such as material on traditional East African dental care, nutritional how-to materials from a Vietnamese American diabetes project and many other topics.

Healthy Roads Media
http://www.healthyroadsmedia.org
A collaboration of several North Dakota agencies, this site provides multimedia health information in several formats, in English, Spanish, Vietnamese, Arabic, Somali, Bosnian, Russian, Hmong, and Khmer.

Multicultural Health Communication Service
http://www.mhcs.health.nsw.gov.au/health-public-affairs/mhcs
From New South Wales, Australia. Hundreds of translated health promotion documents in 50 languages including Arabic, Chinese, Croatian, English, Italian, Korean, Macedonian, Portuguese, Pushto, Russian, Sinhalese, Sorani (Kurdish), Spanish, Tamil, Thai, Turkish, Vietnamese, and many others. No non-Roman fonts are needed because the documents are scanned and presented as Adobe Acrobat .pdf files. Display quality varies.

NOAH: New York Online Access to Health
http://www.noah-health.org
Bilingual English and Spanish website providing hundreds of online health promotion brochures in English and Spanish. NOAH has begun to introduce materials in additional languages.

SPIRAL: Selected Patient Information Resources in Asian Languages
Collaboration between South Cove Community Health Center and Tufts University
http://www.library.tufts.edu/hsl/spiral
Dozens of documents on 27 topics in seven Asian languages. Unlike most sources, SPIRAL explains its selection criteria.

Mental Health

Geneva Initiative on Psychiatry translations database
http://www.geneva-initiative.org/pages/translation_database/translation_database.asp
Searchable by language, ISBN, topic, author, category, and English title, this database contains records of mental health documents in mostly Eastern European languages. Most materials here are books, and many records contain ordering information.

Geriatric Depression Scale
http://www.stanford.edu/%7Eyesavage/GDS.html
This site provides the original English version and translations in Chinese, Danish, Dutch, French, German, Greek, Hebrew, Hindi, Hungarian, Icelandic, Italian, Japanese, Korean, Lithuanian, Malay, Portuguese, Rumanian, Russian, Spanish, Swedish, Thai, Turkish, Vietnamese, and Yiddish. Includes sources where available, and a disclaimer.

Harvard Program in Refugee Trauma (HPRT) Mental Health Screening
http://www.hprt-cambridge.org/Layer3.asp?page_id=33
Three screenings are available in multiple languages: The Hopkins Symptom Checklist-25, Harvard Trauma Questionnaire, and a simple screen for depression. Free registration is required for access. The program's site offers other refugee health resources in addition to the screenings.

Mental Health Instruments in Non English Languages: Research Literature on Multilingual Versions of Psychiatric Assessments Instruments
http://www.vtpu.org.au/resources/translatedinstruments/index.php
Victorian Transcultural Psychiatry Unit, Australia
This extensive bibliography lists literature on over 60 assessment instruments in various languages and includes a table showing the languages in which many are available. Not full text.

Mentasana.com
http://healthinmind.com/Spanish/default.htm
(Health in Mind.com in English, **http://www.healthinmind.com/english/default.html**)
Offered in Spanish and English and voluntarily authored by clinical psychologists, Healthinmind.com/Mentasana.com, presents mental health information in medium register language with a structure based on the DSM-IV. A typical entry contains a description of a disorder and a few recommended books and links. In addition, there's information for families, information about getting services, emergencies, latest news, and more. Not everything is offered in both languages.

Multicultural Mental Health Australia translated information
http://www.mmha.org.au/TranslatedInformation/
This Australian database indexes a variety of resources, some internal to its parent organization, most external. Some are available via the internet, others by mail, some are free, others are not. Each resource has its own record in the system, with contact information, URL, citation or whatever relevant information is required to lead the user to the source.

National Institute of Mental Health Información en Español
http://www.nimh.nih.gov/publicat/spanishpubs.cfm
Detailed Spanish language patient education documents about common conditions such as depression, schizophrenia, panic disorder, anxiety disorder, bipolar disorder, and others. The publications run between 20 and 50 pages, some are available in English also, some are available in .pdf and html while others are only offered in html.

Women's Health

Asian Pacific Islanders Women's Health
http://www.apanet.org/~fdala/
Information on cervical and breast cancer screenings in Samoan, Cambodian, Laotian, Chinese, Vietnamese, Korean, and Thai.

National Women's Health Information Center
English: **http://www.4women.gov/**
Spanish: **http://www.4women.gov/spanish/index.htm**
U.S. Government-approved women's health information. The English site also links to a few Chinese language resources.

"No One Has the Right To Hurt You, Even Someone You Love: Questions and Answers for Refugee Women."
http://www.dhs.ca.gov/hisp/ochs/refugeehealth/html/educmaterials.htm
California Department of Health Services, Refugee Health Section has a very informative brochure about domestic violence in 10 languages. Call the Refugee Health Section at (916) 322-2087 about ordering free copies in all languages.

REPROLINE — Reproductive Health Online
http://www.reproline.jhu.edu
This site offers materials, in English, Spanish, French and Russian. These are high-quality, well illustrated documents, but they are most suitable for an educated audience.

HIV/AIDS and STDs

CDC National Prevention Information Network
http://www.cdcnpin.org/scripts/pubs/matlpubsearch.asp
HIV, TB, and STD prevention information. The database must be searched for translated materials, but they are there.

State Family Planning Administrators
http://www.ourbodiesourselves.org/uploads/pdf/stdlist.pdf
A list of STD/HIV client education materials for linguistically diverse populations offers various materials in up to 30 languages.

Cancer

Asian and Pacific Islander Cancer Education Materials Tool
http://www.cancer.org/apicem
This tool provides links to participating websites that have Asian or Pacific Islander education materials on them. The materials referenced here have been screened by the participating websites for medical accuracy and cultural relevance. Materials are available in Khmer, Chamorro, Chinese, Hawaiian, Hmong, Ilokano, Korean, Samoan, Tagalog, Tongan and Vietnamese, as well as English-language materials culturally tailored for Native Hawaiian populations. Additional languages and topics will be added as more materials become available.

Cancerindex.org
http://www.cancerindex.org/clinks13.htm
Mostly European languages and Japanese.

Diabetes

Diabetes Australia Multilingual Internet Resource
http://www.diabetesaustralia.com.au/multilingualdiabetes/
Materials on numerous diabetes subjects in English, Arabic, Hindi, Chinese, Croatian, Serbian, Thai, Vietnamese, Ukrainian, Turkish, Italian, Greek, Malaysian, and Indonesian.

Diabetes y la Nutrición
(Spanish language Diabetes Nutrition Series)
National Institute of Diabetes & Digestive & Kidney Diseases
http://www.niddk.nih.gov/health/diabetes/pubs/nutritn/index.htm
Dietary information for those with diabetes. Print copies can also be ordered. HTML and pdf versions of the following:
Tengo Diabetes: ¿Qué Debo Comer? (I Have Diabetes: What Should I Eat?)
Tengo Diabetes: ¿Cuánto Debo Comer? (I Have Diabetes: How Much Should I Eat?)
Tengo Diabetes: ¿Cuándo Debo Comer? (I Have Diabetes: When Should I Eat?)

National Diabetes Education Program
http://www.ndep.nih.gov/campaigns/TCH/TCH_materials_AsianAm.htm
Diabetes brochures in 16 Asian languages.

Other

Emergency Multilingual Phrasebook
British Red Cross, with advice and funding from the Department of Health, 2004.
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4073230&chk=8XboAN
The Emergency Multilingual phrasebook, produced and updated by the British Red Cross Society is translated into 36 languages. It covers the most common medical questions and terms to help first contact staff communicate with patients who do not speak English and make an initial assessment while an interpreter is contacted.

Immunization Action Coalition Free Print Materials
http://www.immunize.org/catg.d/free.htm#resourcematerials
Mostly English and Spanish materials on various vaccinations, immunization concerns, and communicable diseases.

Immunization Action Coalition
Vaccine Information Statements (VISs) in 24 languages.
http://www.immunize.org/vis

Low Literacy Bibliography of Materials from the NCEMH Library
National Center for Education in Maternal and Child Health, July 1998
http://www.ncemch.org/databases/PDFs/Bib%20PDFs/Lowlit.pdf
Forty-nine page bibliography offers contact information for ordering materials developed at a low literacy level; some are available in Spanish and other languages.

National Asian Pacific Center On Aging
http://www.napca.org
Materials on Medicare, Medicaid, managed care, and long-term care in Chinese, Korean, Tongan, Vietnamese, Samoan, and Tagalog. Click on "Help for Health" on the right-hand menu.

National Dissemination Center for Children with Disabilities
http://nichcy.org/spanish.htm
NICHCY site in Spanish. It's not readily apparent how they derive this acronym from the organization's full name. The site offers information regarding many childhood disabilities in Spanish.

Suc Khoe La Vang (Health is Gold)
http://www.suckhoelavang.org/main.html
This Vietnamese health organization is connected with the University of California San Francisco who have done anti-tobacco work in the Vietnamese community.

How to Quit Smoking (Vietnamese and English)
http://www.suckhoelavang.org/archives/ltndbht/ltndbht.pdf

Thuoc La Va Gia Dinh (Tobacco and Family) (Vietnamese)
http://www.suckhoelavang.org/tobacco/pdf/thuoclg.pdf
Includes color photographs of a family and some smoke-damaged lungs.

Spanish Specific and English/Spanish

CDC en Español /Centers for Disease Control and Prevention
http://www.cdc.gov/spanish/
The English and Spanish sites aren't identical but there's plenty of material on the Spanish site.

Centro Nacional de Diseminación de Información para Niños con Discapacidades
National Dissemination Center for Children with Disabilities
http://nichcy.org/spanish.htm
NICHCY site in Spanish. The site offers information regarding many childhood disabilities in Spanish.

Diabetes y la Nutrición/Spanish language Diabetes Nutrition Series
National Institute of Diabetes & Digestive & Kidney Diseases
http://www.niddk.nih.gov/health/diabetes/pubs/nutritn/index.htm
Description: Dietary information for those with diabetes. Print copies can also be ordered. HTML and PDF versions of the following:

Tengo Diabetes: ¿Qué Debo Comer? (I Have Diabetes: What Should I Eat?)

Tengo Diabetes: ¿Cuánto Debo Comer? (I Have Diabetes: How Much Should I Eat?)

Tengo Diabetes: ¿Cuándo Debo Comer? (I Have Diabetes: When Should I Eat?)

Direcorio de Recursos/Resources Directory
Patient Education for University of Utah Health Sciences Center
http://www.med.utah.edu/pated/handouts/indexspan.cfm
Numerous patient education materials in Spanish.

Healthfinder en Español
http://www.healthfinder.gov/español/
Consumer health site from the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. The alphabet along the bottom takes the user to far more subjects.

Institutos Nacionales de la Salud/ National Institutes of Health
http://salud.nih.gov/
National Institutes of Health in Spanish (United States)

Medicinatv
http://salud.medicinatv.com/
Spanish language site that links to 10,000 health-related sites.

MEDLINEPlus Espanol
http://medlineplus.gov/spanish/
MEDLINEPlus.gov is a bountiful source of authoritative and up-to-date health information from the world's largest health library, the National Library of Medicine. The Spanish version, which is less extensive than the English one, includes content on drug information, a medical encyclopedia with illustrations and diagrams, a dictionary, current health news, and over 175 interactive slideshow tutorials with sounds and pictures.

Easy-to-Read Health Resources

MEDLINEPlus.gov
http://nnlm.gov/hip/easy.html
Dozens of easy-to-read patient education materials, mostly in English but many available in Spanish.

Mentasana.com
http://healthinmind.com/Spanish/default.htm (Health in Mind.com in English, **http://www.healthinmind.com/english/default.html**)
Offered in Spanish and English and voluntarily authored by clinical psychologists, Healthinmind.com/Mentasana.com, presents mental health information in medium register language with a structure based on the DSM-IV. A typical entry contains a description of a disorder and a few recommended books and links. In addition, there's information for families, information about getting services, emergencies, latest news, and more. Not everything is offered in both languages.

National Dissemination Center for Children with Disabilities
http://nichcy.org/spanish.htm
NICHCY site in Spanish. It is not readily apparent how they derive this acronym from the organization's full name. The site offers information regarding many childhood disabilities in Spanish.

National Center for Farmworker Health
http://www.ncfh.org/00_ns_rc_pateduc.php
This link accesses ten nicely-illustrated bilingual downloads, originally developed for use as a patient education tool to supplement and enhance existing teaching methods in migrant health centers and in outreach programs.

National Institute of Mental Health Información en Español
http://www.nimh.nih.gov/publicat/spanishpubs.cfm
Detailed Spanish language patient education documents about common conditions such as depression, schizophrenia, panic disorder, anxiety disorder, bipolar disorder, and others. The publications run between 20 and 50 pages, some are available in English also, some are available in PDF and HTML while others are only offered in HTML.

NN/LM's Consumer Health Materials in Spanish page

http://nnlm.gov/scr/conhlth/chspanish.htm

Lorna Springston and Marsha Sullivan. Numerous sources for Spanish language consumer materials. A few dead links, and many sites require the user to find the Spanish materials link on the page, but plenty of content is accessible from here, from book and video distributors to materials from associations and federal agencies.

Bilingual Dictionaries and Glossaries, Online, in Print, and Other Formats

Sources for Bilingual Dictionaries and Glossaries

California Health Interpreters Association (CHIA) list of online multilingual medical glossaries
http://chia.ws/pdf/annotated_bibliography.pdf

InTrans Book Service
http://intransbooks.com/
InTrans Book Services specializes in books for interpreters and translators, mostly in the Spanish and English language pair.

Schoenhof's Foreign Books
http://www.schoenhofs.com/
Extensive selection of multilingual medical and general dictionaries from around the world.

Cross Cultural Health Care Program
http://www.xculture.org/resource/order/
Medical glossaries available in 17 languages; translated by professionals & reviewed by MDs.

Bibliography of Bilingual Dictionaries and Glossaries

The following list includes health-related, general, and a few other specialized bilingual dictionaries. Clearly, not every language encountered in health care settings in the United States is represented. Dictionaries vary from affordable pocket dictionary-style references, easy to transport but lacking in detail, to large and sometimes expensive volumes printed in South Asia and other parts of the world. The authors have not evaluated these resources for quality and inclusion here does not constitute an endorsement.

Albanian
Albanian-English, English-Albanian dictionary by Ilo Stefanllari. — New York NY: Hippocrene Books, 1996.

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Random House Webster's American sign language medical dictionary by Elain Costello. Lois a. Lehman, Illustrations; Linda C. Tom, Illustrations. — New York NY: Random House, 2000.

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English-Amharic medical glossary by Fisseha Engida, translator; Clancy J. Clark, English definitions & editing; Many others, word selection & reviews. Cross Cultural Health Care Program — [Seattle WA]: CCHCP, 1999.

Arabic

Arabic-English and English-Arabic Dictionary by John Wortabet; Harvey Porter; Librairie du Liban (Beirut,Lebanon) — Troy MI: International Book Centre, 1991 printing.

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A Dictionary of Iraqi Arabic : English-Arabic Arabic-English by Beverly E. Clarity, et al., Editors. — Washington DC: Georgetown University Press, 2003.

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Samsad Bengali-English dictionary by Sailendra Biswas, Birendramohan Dasgupta, Subodhchandra Sengupta. — Calcutta, India: Sahitya Samsad, Second edition, 1982. 24th impression, 1995.

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Bosnian-English, English-Bosnian dictionary by Nokolina S. Uzicanin, Nikolina S. — New York NY: Hippocrene Books, 1996.

Health Care Interpreter Program medical glossary: English-Serbo/Croatian/Bosnian by Verdran Uscuplic, Elvisa Abadyri. — Houston TX: Refugee Services Alliance, 1998.

Bulgarian

Bulgarian-English dictionary volumes 1 & 2 by T. Atanassova et al. — Sophia, Bulgaria: Naoka I Izkoustvo 11, Slaveikov SC, 1995.

NTC's Bulgarian and English dictionary by Elena Stankova, Ivanka Harlakova. — Lincolnwood IL: National Textbook Company, 1994.

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Chinese-English two-way dictionary 3.0. Intense Language Office. — Monterey Park CA: TwinBridge Software Corporation, 1997.

English-Chinese, Chinese-English dictionary of Chinese medicine by Nigel Wiseman. — Beijing: Hunan Science & Technology Press, 1996.

English-Chinese medical dictionary. — Hong Kong: People's Health Publishing Company Press, 1988.

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English-Croatian dictionary = Englesko-Hrvatski rjecnik by Rudolf Filipovic, et al. — Zagreb, Croatia: Skolska Knjiga, 1998.

An English-SerboCroatian dictionary = Englesko-Srpskohrvatski recnik by Morton Benson — New York, NY: Cambridge University Press, 1990.

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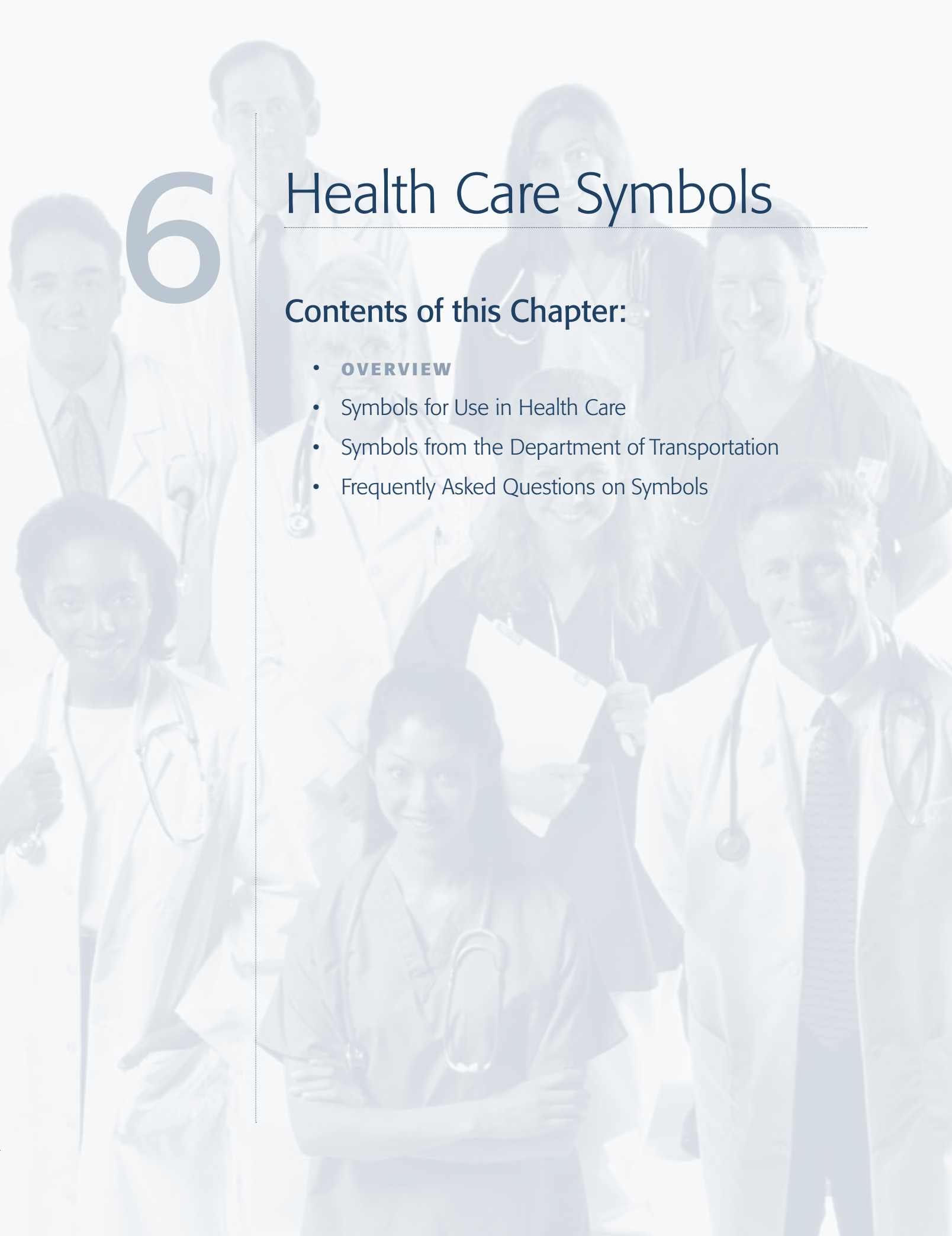
6 Health Care Symbols

Contents of this Chapter:



Overview[57]

One way that health care facilities, especially larger ones like hospitals and clinics, can assist LEP patients is to utilize signage and symbols to assist with "wayfinding." Wayfinding refers to the method for providing information to guide a person to their destination. Translated signs and/or symbols can be part of wayfinding systems. Multilingual signs can directly assist speakers of your most frequently encountered languages. But if your facility frequently encounters a variety of languages, having multiple translated signs may not be realistic because of special, financial, or other constraints such space limitations and the need to meet ADA requirements. Symbols can function as a universal language understandable by speakers of a variety of languages and may be a useful alternative to multilingual signs.

Hablamos Juntos ("We Speak Together"), a project of the Robert Wood Johnson Foundation, undertook a project to develop symbols for use in health care settings. Their website includes a wealth of information about symbols including 28 health care symbols, information on how to implement usage of these symbols, tool kits, a best practice workbook, and frequently asked questions. The 28 health care symbols developed are:

Ambulance Entrance	Intensive Care	Pediatrics
Billing Department	Internal Medicine	Pharmacy
Cardiology	Interpreter Services	Physical Therapy
Care Staff Area	Laboratory	Radiology
Chapel	Mammography	Registration
Diabetes	Medical Records	Social Services
Emergency	OB Clinic	Surgery
Family Practice	OB/GYN	Waiting Areas
Immunizations	Oncology	
Infectious Diseases	Outpatient	

In addition, symbols developed by other organizations may be useful in health care settings. For example, relevant Department of Transportation (DOT) symbols include:

Accessibility	Hearing Assistance	Restrooms
Coffee Shop	Hospital	Smoking
Drinking Fountain	Information/US	Stairs
Elevators	No Smoking	Telephone
Fire Extinguisher	Nursery	Volume Control
Gift Shop	Restaurant	First Aid

The following pages, reprinted with permission from Hablamos Juntos, provide initial information about symbols. Much more information is available on their website, **www.hablamosjuntos.org**.

Symbols for Use in Health Care

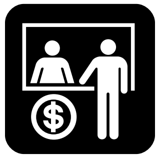
Hablamos Juntos, an initiative of The Robert Wood Johnson Foundation, was launched to eliminate language barriers and improve the quality of health care for people with Limited English Proficiency (LEP). In a research endeavor with JRC Design, they examined the history and usage of visual symbols as communication tools in health care settings throughout the world.

The research showed that symbols can be an effective communications tool, particularly for LEP individuals. Further, a thoughtful, well-designed symbol system could assist English speakers as well as LEP people of many languages and cultures.

The symbols shown on this poster are the results of rigorous design and testing. It's a system with broad aesthetic as well as practical appeal.

Symbols are not the panacea for a poor signage system, nor will they solve wayfinding issues. But they can be part of a viable and dynamic system that can assist all people, regardless of their reading skill level, to feel more comfortable and confident within a health care facility.

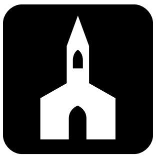
Ambulance Entrance
Ingreso de Ambulancias



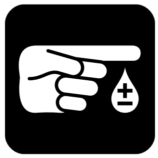
Billing Department
Departamento de Facturación

Cardiology
Cardiología

Care Staff Area
Área del Personal de Cuidado



Chapel
Capilla

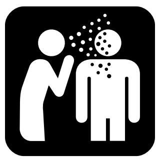


Diabetes (Education)
Diabetes (Educación)

Emergency
Emergencia

Family Practice Clinic
Clínica de Practica Familiar

Immunizations
Inmunizaciones



Infectious Disease
Enfermedades Infecciosas

Intensive Care
Cuidado Intensivo

Internal Medicine
Medicina Interna

Interpretive Services
Servicios Interpretacion

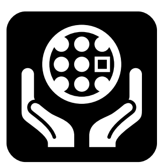
Laboratory
Laboratorio

Mammography
Mamografía

Medical Records
Archivos Médicos

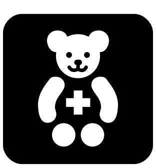
OB Clinic
Clínica de Obstetricia

OB/GYN
Obstetricia/ Ginecología



Oncology
Oncología

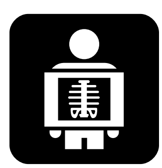
Outpatient
Paciente Ambulatorio



Pediatrics
Pediatría

Pharmacy
Farmacia

Physical Therapy
Terapia Física



Radiology
Radiología

Registration
Registro

Social Services
Servicios Sociales

Surgery
Cirugía

Waiting Area
Área de Espera

Hablamos Juntos

The Robert Wood Johnson Foundation

JRC Design

Symbols from the Department of Transportation

Frequently Asked Questions on Symbols[58]

1. Why would I use symbols in my sign system?
2. Where can I get the symbols for use on signs?
3. How much does it cost to use the symbols?
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6. What does wayfinding mean?
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8. Why were these referents chosen to develop symbols?
9. How were the symbols designed?
10. What is the significance of ≤87 and >87 to the testing?
11. Did all the symbols in this set receive scores >87?
12. Will there be additional symbols developed?
13. Can I use these symbols as a logo for my medical business?
14. Our facility could use the symbols, but some of the referents differ from our terminology. Can we still use the symbols?

1. **Why would I use symbols in my sign system?**

   A picture is worth a thousand words. Health facilities are struggling to meet federal laws requiring signage in the languages of their patients. Because health care facilities serve patients that speak many different languages, meeting the wayfinding needs for these patients can not be done well with typical signs. Multilingual signs can be expensive and difficult to accommodate in most wayfinding programs. Research has shown that symbols are an effective means of communication for people with Limited English Proficiency (LEP) regardless of their primary language.

2. **Where can I get the symbols for use on signs?**

   The health care symbols developed through Hablamos Juntos can be downloaded from **www.hablamosjuntos.org**, as the complete group in PDF. That means they can be opened and read in Adobe Acrobat Reader, as well as most vector-based software programs such as Adobe Illustrator, Corel Draw, AUTOCAD, etc. Vector-based software will allow the symbols to be accessed and used for other applications such as signs.

3. **How much does it cost to use the symbols?**

   The symbols and any materials developed to aid in their use are free. Upon completion of the initial set, the symbols were designated as public domain, thanks to the grant of the Robert Wood Johnson Foundation.

4. **Can I change these symbols?**

   No. Although these symbols are free and permission is not needed to use them, but the images have been protected by the Robert Wood Johnson Foundation under United States copyright law. The value of the symbols is in their ability to convey the information they were designed to convey. This comes with the public's ability to recognize they symbols' intended meaning. Modifications or changes to the symbols works against this important goal.

5. **Our signage is not very good, will adding these symbols help?**

   The symbols are meant to be adaptable and to be used in any signage system, but were designed as complete images to follow the recognized DOT standards. Image within a rounded corner square and proportioned negative space around them. They were also designed to be used in the reverse. When using the symbols in either positive or negative form, you should follow best practices for contrast and size for the environment and ADA guidelines.

   ADA guidelines state that when symbols are used to identify a space (wall mounted identification sign), they must be within a designated 6" field; that field can be any shape, but must provide a separation from everything else around it. That shape is not specifically dictated to the one around these symbols. For example, California's Unified Building Code (UBC) requires

the use of a circle and triangle with the women's and men's symbols to identify restrooms. So if using different shapes, careful consideration should be used so not to create confusion as to the meaning of the symbol and/or the shape it is in.

6. What does wayfinding mean?

Wayfinding is the method for providing consistent and overt information that can guide a person to their destination. This information can be through maps and signs, clues embedded in the architecture or through the use of color, pattern and texture in the interior design of a facility. Wayfinding is more than signs. It is the practice of looking at navigating your facility from a visitor's perspective, understanding why your visitors are there and using this information to design information and clues to help guide your visitors to their destinations.

7. I don't see some symbols that I need. Why not?

Symbols are a universal language, which means the language of health care symbols needs to be learned. Based on research conducted for the project, having too many symbols would create challenges in learning what each symbol means. By starting with a small set of symbols users can begin learning this new language. Over time it is envisioned that new additional symbols will be added.

8. Why were these referents chosen to develop symbols?

The health care symbols include 28 referents commonly found in health facilities. These were identified as priority terms through surveys conducted in the ten Hablamos Juntos demonstration sites. A survey containing over 200 terms in nearly 60 categories was given to hospital administrators, staff, social workers and others in health facilities participating in the Hablamos Juntos demonstrations located throughout the country. Respondents were asked to select the top 30 terms representing locations visitors most frequently used in their facilities. The results were tabulated, and the top 30 terms overall were determined.

9. How were the symbols designed?

All the health care symbols were designed for this project. You may find elements you've seen before. This is because initially, existing symbols were collected and associated with one or more of the references included in the project. These existing symbols were analyzed for the concepts used to represent the referent. A team of designers with expertise in health care, symbol and graphic design, selected existing symbols or designed new ones. Over 600 symbols were evaluated or created for the project. Through a survey method, successfully used in many different countries and adopted by the International Organization for Standardization (ISO), symbols were tested for comprehensibility with four language groups.

In the Comprehension Estimation survey, for each referent, five or six symbols were displayed and survey responders were asked to estimate the percent of the population that spoke their language would comprehend the symbols to mean the referent. Three rounds of surveys were conducted in ten states; bilingual survey administrators and interpreters were used to reach limited English speaking respondents. Ultimately, nearly 300 persons, from four language groups (English, Spanish, Indo European and Asian languages) took part in the surveys. After each round, symbols that received scores greater than 87 were retained and retested for potential use in the final symbol set. Symbols that tested less than 87 were modified and retested or discarded depending on the rating.

10. What is the significance of <87 and >87 to the testing?

The symbols were tested through a well-known survey method call Comprehension Estimation testing. This method has been used in many different countries and adopted by the International Organization for Standardization (ISO) because it produces consistent and reliable results. The instrument has the accepted threshold of greater than 87 percent as a measure of effectiveness. In other words, symbols that achieve a rating of greater than 87 percent are found to be comprehended by a vast majority.

11. Did all the symbols in this set receive scores >87?

No. 17 symbols had at least one symbol that achieved scores greater than 87. When more than one symbol for the same referent achieved this threshold, the design team had options to select the strongest symbols for inclusion into the set. Most often, those turned out to be the symbols receiving the highest scores. Eleven symbols did not reach the threshold. These were generally referents with no single or common meaning such as oncology, or less commonly understood referents such as diabetes. The symbols selected for these referents were informed by the test results and rely on features that worked well in the higher rated symbols.

12. Will there be additional symbols developed?

Hablamos Juntos with demonstrations in ten states offered a unique opportunity that will be expensive to replicate. The Society for Environmental Graphic Design (SEGD) is evaluating the possibility of continued health care symbol design through the proven testing procedures, but no official program has been established.

13. Can I use these symbols as a logo for my medical business?

The power of symbols comes with linking the image to the concept. These symbols were developed for use as wayfinding tools. To the degree that symbols help communicate specific destinations, medical services or health activities we

anticipate the use of symbols will go beyond their original purpose. However, using them as a logo or for marketing purposes is not recommended.

14. Our facility could use the symbols, but some of the referents differ from our terminology. Can we still use the symbols?

Yes. Public education is the key to success. Symbols can be used with referents that are closely related (X-Ray, Imaging, Radiology). These symbols were developed and tested to link a referent with a concept and image. Definitions were made as simple as possible while still conveying the basic meaning. Substituting a similar referent and definition can be successful with public education. Keep in mind that translations for major language groups are available only for the original referents and definitions used in the testing.

7 Brief Guide to U.S. Department of Health & Human Services Office for Civil Rights Resources

Contents of this Chapter:

Overview[59]

The Office for Civil Rights (OCR) is part of the federal Department of Health and Human Services (HHS). Located within the HHS Secretary's Office, OCR's purpose is to ensure that users of Health and Human Services programs have equal access and service quality in those programs as protected by federal civil rights legislation. In addition to its headquarters office in Washington DC, OCR operates 10 regional offices.

OCR offers technical assistance to health care providers who need help in determining how to provide language services to their patients/clients. OCR has primary responsibility within HHS for oversight of language access and national origin discrimination. The OCR regional offices are available for consultation and can also conduct on-site trainings. In addition, OCR investigates complaints filed against federal fund recipients for failing to provide language services.

The following pages provide a summary of OCR's services and resources and how to access them. With the exception of some explanatory notes, this information is all available from OCR's website. Much of it is also available from regional offices, which are listed near the end of this chapter.

The OCR website provides a wealth of information for both consumers and the programs covered by its jurisdiction.

Resources include but are not limited to:

- fact sheets providing general information about OCR in multiple languages
- fact sheets demystifying patients' rights in multiple languages
- medical provider certification for receiving federal Medicare funds
- text of federal regulations and guidance memoranda, including the LEP Guidance
- instructions and "frequently asked questions" on how to file civil rights complaints
- glossary of related terms

Selected OCR Publications and Resources

1. **Limited English Proficiency Video**
   http://srb-hud.irides.com:8080/ramgen/srbhud/real/hud/2005/0318/wc-05450-en-cc-150k.rm?usehostname

   This online 36-minute video provides a brief introduction to the legal issues around interpreting as well as excellent demonstrations of why professional interpreters' services are necessary in health care, their role, and how to utilize a trained medical interpreter. This compelling video is free and can be watched on a computer screen. It can be found on the OCR home page on the left-hand menu.

2. **Civil Rights Clearance for Provider Certification**
   http://www.hhs.gov/ocr/crclearance.html

   This section features numerous documents that aid providers and institutions in achieving compliance with civil rights law in various aspects of care, in order to be Medicare providers. Resources include but are not limited to:

   - OCR information request form and HHS Form 690 (Assurance of Compliance Form)
   - Technical assistance/legal information on:
     - nondiscrimination policies
     - communication with LEP patients
     - auxiliary aids for persons with disabilities
     - age discrimination, and requirements
     - requirements for facilities with 15 or more employees
   - Regulations and guidance such as
     - Title VI of the Civil Rights Act: 45 CFR Part 80
     - Limited English Proficiency (LEP)

   Note: Medicare is solely funded by and providers are certified to serve Medicare patients through the federal government, while Medicaid is a joint federal-state funded and administered program where each state determines who may be a Medicaid provider. That is why this section of OCR's resources pertains to Medicare and not Medicaid.

3. **Filing a HIPAA Privacy Complaint**
   Information on filing a HIPAA privacy complaint can be found in a fact sheet at: **http://www.hhs.gov/ocr/privacyhowtofile.htm**

   Other HIPAA information includes sample contracts for businesses; consumer information, some of it in Spanish and easy-to-read English; "frequently asked questions"; a listserv to join; and links to related sites.

4. **Civil Rights Fact Sheets for Consumers**

   English: **http://www.hhs.gov/ocr/generalinfo.html**

   Other Languages: **http://www.hhs.gov/ocr/factsheets/**

   OCR provides these fact sheets in multiple languages—Chinese, English, Korean, Polish, Russian, Spanish, Tagalog, and Vietnamese. A separate web page is dedicated to each language. The English, Polish, Spanish, and Tagalog pages are in HTML, while the Chinese, Korean, Russian, and Vietnamese pages are PDF files, requiring Adobe Acrobat Reader to view. All contain hyperlinks to multiple translated documents. The following are available in most of the languages:

   - How to file a Discrimination Complaint with the Office for Civil Rights
   - Know Your Civil Rights
   - Your Rights under Title VI of the Civil Rights Act of 1964
   - Your Rights under Section 504 of the Rehabilitation Act
   - Your Rights under the Americans with Disabilities Act
   - Your Rights under Section 504 and the Americans with Disabilities Act
   - Your Rights under the Community Service Assurance of the Hill-Burton Act
   - Your Rights as a person with HIV infection or AIDS
   - Your Rights under the Age Discrimination Act
   - How to File a Health Information Privacy Complaint with the Office for Civil Rights
   - Limited English Proficiency (LEP) Know Your Rights brochure

5. **Civil Rights Complaint FAQ**

   A Frequently Asked Questions document about filing a civil rights complaint is available at **http://www.hhs.gov/ocr/newfaq.html**. This FAQ provides answers to common questions about topics such as details of the complaint process, how various situations are handled, what information is needed from the inquiring person, limitations on the types of complaints investigated, what to expect, other federal agencies that handle civil rights and discrimination issues, and other topics.

OCR Regional Offices

Health care providers seeking technical assistance from OCR in assessing and implementing language services should contact their regional office for assistance.

Region	Manager, Email, Web[60]	Phone and fax	Address
Headquarters Washington, DC	Winston Wilkinson, Director OCRMail@hhs.gov www.hhs.gov/ocr/index.html	**T:** 800-368-1019 **TDD:** 800-537-7697	Office for Civil Rights U.S. Department of Health and Human Services (OCR DHHS) 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, DC 20201
Region I — Boston (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)	Peter Chan, Acting Regional Manager	**T:** 617-565-1340 **F:** 617-565-3809 **TDD:** 617-565-1343	OCR DHHS Government Center J.F. Kennedy Federal Building — Room 1875 Boston, MA 02203
Region II — New York (New Jersey, New York, Puerto Rico, Virgin Islands)	Michael Carter, Regional Manager	**T:** 212-264-3313 **F:** 212-264-3039 **TDD:** 212-264-2355	OCR DHHS Jacob Javits Federal Building 26 Federal Plaza — Suite 3312 New York, NY 10278
Region III — Philadelphia (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia)	Paul Cushing, Regional Manager	**T:** 215-861-4441 **Hotline:** 800-368-1019 **F:** 215-861-4431 **TDD:** 215-861-4440	OCR DHHS 150 S. Independence Mall West Suite 372, Public Ledger Building Philadelphia, PA 19106-9111
Region IV — Atlanta (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)	Roosevelt Freeman, Regional Manager	**T:** 404-562-7886 **F:** 404-562-7881 **TDD:** 404-331-2867	OCR DHHS Atlanta Federal Center, Suite 3B70 61 Forsyth Street, S.W. Atlanta, GA 30303-8909
Region V — Chicago (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)	Jerome Meites, Acting Regional Manager	**T:** 312-886-2359 **F:** 312-886-1807 **TDD:** 312-353-5693	OCR DHHS 233 N. Michigan Ave., Suite 240 Chicago, IL 60601
Region VI — Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)	Ralph Rouse, Regional Manager	**T:** 214-767-4056 **F:** 214-767-0432 **TDD:** 214-767-8940	OCR DHHS 1301 Young Street, Suite 1169 Dallas, TX 75202
Region VII — Kansas City (Iowa, Kansas, Missouri, Nebraska)	Fred Laing, Acting Regional Manager	**T:** 816-426-7278 **F:** 816-426-3686 **TDD:** 816-426-7065	OCR DHHS 601 East 12th Street — Room 248 Kansas City, MO 64106
Region VIII — Denver (Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming)	Velveta Howell, Regional Manager	**T:** 303-844-2024 **F:** 303-844-2025 **TDD:** 303-844-3439	OCR DHHS 1961 Stout Street — Room 1426 FOB Denver, CO 80294-3538
Region IX — San Francisco (American Samoa, Arizona, California, Guam, Hawaii, Nevada)	Ira Pollack, Regional Manager	**T:** 415-437-8310 **F:** 415-437-8329 **TDD:** 415-437-8311	OCR DHHS 50 United Nations Plaza — Room 322 San Francisco, CA 94102
Region X — Seattle (Alaska, Idaho, Oregon, Washington)	Linda Yuu Connor, Deputy Regional Manager	**T:** 206-615-2290 **F:** 206-615-2297 **TDD:** 206-615-2296	OCR DHHS 2201 Sixth Avenue — M/S: RX-11 Seattle, WA 98121-1831

8 Glossary of Interpreting and Translation Terms

Glossary[61]

"A" language — A language in which the interpreter has native proficiency in speaking and listening.

accreditation — A term usually referring to the recognition of educational institutions or training programs as meeting and maintaining standards that qualify its graduates for professional practice. See also **certified interpreter**.

ad hoc interpreter — An untrained person who is called upon to interpret, such as a family member interpreting for her parents, a friend, a bilingual staff member who is pulled away from other duties to interpret, or a self-declared bilingual individual who volunteers to interpret. These individuals may not have sufficient language capability or knowledge of medical terminology and confidentiality issues to function adequately as interpreters. Also called a *chance interpreter* or *lay interpreter*.

advocacy — Any intervention (by an interpreter) that does not specifically relate to the interpretation process. Advocacy is intended to further the interests of one of the parties for whom the interpreting is done. For example, if an interpreter intervenes when she believes the physician is not giving the patient a chance to describe the problem she made the appointment to address, that intervention would be considered advocacy. Experts in the field of health care interpreting disagree on the degree of advocacy that interpreters should provide. This is the subject of an ongoing national dialogue. See also **transparency**.

advocate — A role that an interpreter takes that moves from interpreting the communication between speakers to acting on behalf of one of the speakers based on the interpreter's understanding of what the speaker's intended outcome is.

autonomy	The principle by which patients who are competent to make decisions should have the right to do so while health care providers should respect patients' preferences regarding their own health care.
"B" language	A language in which the interpreter has full functional proficiency in speaking and listening.
back translation	Translation of a translated document back into the original language. Often used to check the accuracy of the original translation, although professional translators do not use this process to check the accuracy of a translation.
bilingual	A term describing a person who has some degree of proficiency in two languages. A high level of bilingualism is the most basic of the qualifications of a competent interpreter or translator but by itself does not insure the ability to interpret or translate.
bilingual provider	A person with proficiency in more than one language, enabling the person to provide services directly to limited English proficient patients in his/her non-English language.
bilingual worker/ employee	An employee who is a proficient speaker of two languages, usually English and a language other than English, who is often called upon to interpret for limited English proficient patients, but who is usually not trained as a professional interpreter. Using a bilingual employee who is neither proficiently bilingual nor trained to interpret is not recommended. See also **professional interpreter**.
Centers for Medicare & Medicaid Services (CMS)	As a part of the U.S. Department of Health and Human Services (HHS), CMS oversees Medicare, Medicaid and State Children's Health Insurance Program (SCHIP).
certificate	A document, such as a certificate of attendance or completion, that attests to participation in a course of study and attainment of some learning objective. A person who holds a certificate related to interpreter training is not thereby **certified**. See also **certification**, **certified interpreter**.

certification

A process by which a governmental or professional organization attests to or certifies that an individual is qualified to provide a particular service. Certification calls for formal assessment, using an instrument that has been tested for validity and reliability, so that the certifying body can be confident that the individuals it certifies have the qualifications needed to do the job. Currently, no national certification standards exist for medical/health care interpretation or translation. Washington State has state-based medical interpreting certification, and Indiana, Massachusetts and Oregon are developing state interpreter certification standards. Rhode Island has a state law mandating that hospitals provide a "qualified interpreter."[62] Some colleges and universities have medical interpreting "certificate" programs, and a variety of health care interpreting training programs exist. Many training programs are 40- to 50-hours in length and issue certificates of completion. These programs do not constitute certification. Sometimes called *qualification*. See also **certified interpreter**.

certified interpreter

A **professional interpreter** who has certification. Interpreters who have had limited training or have taken a screening test administered by an employing health, interpreter or referral agency are not considered certified. See also **certification**.

clarifier

An interpreter who helps a speaker explain a message or concept in a more easily understood way to facilitate communication between parties during an interpreting session.

community interpreting

Interpreting that takes place in the course of communication in the local community among speakers of different languages. The community interpreter may or may not be a trained interpreter. See **professional interpreter**.

conduit	The basic role of an interpreter, to reproduce everything that one party says in one language into the target language, exactly as it is said, adding nothing, omitting nothing, and changing nothing. See also **clarifier**.
consecutive interpreting	The conversion of a speaker's message into another language in a sequential manner after the speaker or signer pauses, in a specific social context. In other words, the interpreter waits until the speaker has finished the utterance before rendering it in the other language. See also **simultaneous interpreting**.
converter	See **conduit**.
cultural and linguistic competence	The ability of health care providers to understand and respond effectively to the cultural and linguistic needs of the patient and his/her family. See also **cultural sensitivity**.
cultural bridging/broker(ing)/ liasing/mediating	Any action taken by the interpreter that provides cultural information in addition to linguistic interpretation of the message given. See also **transparency**.
cultural sensitivity	Awareness of one's own cultural assumptions, biases, behaviors and beliefs, and the knowledge and skills to interact with and understand people from other cultures without imposing one's own cultural values on them.
Department of Health and Human Services (United States) (DHHS or HHS)	DHHS administers many of the programs at the Federal level dealing with the health and welfare of the residents of the United States.[63] In August 2003, HHS issued an LEP guidance to inform recipients of HHS funds of the expectations to provide meaningful access to LEP individuals. In the health care context, the guidance applies to most hospitals, doctors (except those only receiving funds through Medicare Part B), nursing homes, managed care organizations, state Medicaid agencies, and social service organizations.

Department of Justice (DOJ) Coordinating Authority

DOJ coordinates the federal government's implementation of Title VI. In June 2002, DOJ issued LEP policy guidance, which provides four factors that federal agencies should use in developing their recipient specific guidance for language access to LEP individuals.[64] These four factors include: (1) the number or proportion of LEP persons served or encountered; (2) the frequency of contact with the program; (3) the nature and importance of the program to LEP beneficiaries; (4) and the resources available and cost considerations.

face-to-face interpreting

Interpreting done by an interpreter who is directly in the presence of the speakers. Also called *on-site interpreting*. See also **remote interpreting**, **telephone interpreting**.

first-person interpreting

The promotion by the interpreter of direct communication between the principal parties in the interaction through the use of direct utterances of each of the speakers, as though the interpreter were the voice of the person speaking, albeit in the language of the listener. For example, if the patient says, "My stomach hurts," the interpreter says (in the second language), "my stomach hurts," and not "she says her stomach hurts."

Executive Order (EO) 13166

President Clinton signed and President Bush reaffirmed EO 13166 to improve access to federally funded programs and activities for persons with LEP, based on Title VI of the 1964 Civil Rights Act. EO 13166 requires each federal agency to develop guidance on language access to its federal fund recipients. It also applies Title VI requirements to federal departments and agencies themselves.[65]

Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (2003)

This guidance was finalized by HHS in 2003 after being reissued to follow the LEP guidance template from the Department of Justice.

HHS

See **Department of Health and Human Services**.

health care interpreting

Interpreting that takes place in health care settings of any sort, including physicians' offices, clinics, hospitals, home health visits, mental health clinics, and public health presentations. Typically the setting is an encounter between a health care provider (physician, nurse, lab technician) and a patient (or the patient and one or more family members). See also **medical interpreting**.

HIPAA (Health Insurance Portability and Accountability Act of 1996)

The Health Insurance Portability and Accountability Act was enacted to simplify health care claims by establishing national standards for electronic claims. In addition, the HIPAA privacy regulations establish a set of minimum national standards that limit the ways that health plans, pharmacies, hospitals, clinicians, and others (called "covered entities") can use patients' personal medical information. For a discussion of how HIPAA affects language services, refer to NHeLP's document *HIPAA and Language Services in Health Care*.[66]

informed consent

The process in which a health care provider informs his/her patient about treatment options and the risks involved and the patient makes a decision regarding what he/she wants to do.

interpretation

See **interpreting**. While the two words have the same meaning in the context of oral/signed communication, the term *interpreting* is preferred, because it emphasizes process while interpretation refers to the product and because *interpretation* has so many other uses outside the field of translation and interpreting.

interpreter

A person who renders a message spoken in one language into a second language. Within the language professions, *interpreting* is distinguished from *translating* according to whether the message is produced *orally* (or manually) or *in writing*. In popular usage, however, the terms "translator" and "translation" are frequently used for conversion of either oral or written communications. See also **professional interpreter**.

interpreting	(noun) The process of understanding and analyzing a spoken or signed message and reexpressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account. The purpose of interpreting is to enable communication between two or more individuals who do not speak each other's languages. (adjective) Concerning or involved with interpreting. Examples: *interpreting services, interpreting issues*.
interpretive	See **interpreting**. Like the word *interpretation, interpretive* has many meanings and is often unclear when used in the context of oral/signed communication. It is preferable to use *interpreting* as an adjective, e.g. *interpreting services, interpreting issues*.
language agency	Organization that provides language services, including interpreting and/or translation. Language agencies can provide services on-site at a health care provider and/or via telephone or video conferencing. There are a variety of for- and non-profit organizations around the country offering these services.
language combination	The two languages that serve as **source** and **target languages** for an individual interpreter in a particular encounter. See also **source language**, **target language**.
language identification cards/ posters	This card identifies the language spoken by an individual ("I speak _____ language") and is often in both English and a target language – the English informs the health care provider of the language needs of the patient. These are commonly referred to as "I Speak" cards or posters.
language pair	See **Language Combination**
LEP	See **Limited English Proficiency**.
licensed	Having formal permission or authority to perform some professional role, such as interpreting. There is no national licensure for medical interpreters in the United States.

licensure

The process of obtaining an official license or authorization to perform a particular job. For example, in every state, a state board grants licensure to physicians, who must meet certain requirements in order to periodically renew their licenses. There is no national licensure for interpreters or translators in the United States.

limited English proficiency (LEP)

The inability to speak, read, write, or understand English at a level that permits an individual to interact effectively with health care providers or social service agencies.[67] According to the 2000 Census, over 21 million individuals speak English less than "very well." Many states have experienced significant increases in their LEP populations because of the changing demographics of the U.S. population.

See also *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (2003) [**http://www.hhs.gov/ocr/lep/revisedlep.html**].

literal interpretation or translation

A form of rough interpreting or translation in which every word or word element is translated in sequence without regard to how the message would normally be expressed in the other language, giving insight into the workings of the source language. Example: (*French*) "*Il y avait beaucoup de gens*," literally "It there had many of people," which means, "There were lots of people (there)." Literal interpreting is not considered useful or part of professional interpreting; literal translations (written) are sometimes useful for analysis of the source text, but are not suitable when the aim is to assist communication.

machine translation

Translation that is accomplished by entering text in one language into a computer software program and obtaining a computed translation in a second language. Machine or computer translation programs often have difficulties recognizing idioms, context, regional differences and symbolic speech.

Medicaid and State Children's Health Insurance Program (SCHIP)

Health insurance programs for certain low-income individuals, operated jointly by the federal and state governments. Medicaid provides health insurance to over 44 million individuals, SCHIP to over 3 million children and sometimes others such as parents and pregnant women. Both programs allow states to draw down federal matching dollars to help pay for language services. At the time of this writing, eleven states (Hawaii, Idaho, Kansas, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah, Vermont and Washington) utilize the federal matching funds for language services. Two additional states, Texas and Virginia, are initiating pilot projects for reimbursement. Health care providers who participate in these programs must abide by Title VI.

medical interpreting

Interpreting that takes place in health care settings, such as between health care providers (physicians, nurses, lab technicians, staff) and patients. The skills needed for medical/health care interpreting vary from other settings, such as court interpreting. Medical/health care interpreters must be aware of confidentiality and HIPAA issues, medical terminology, and how to work in the health care setting.

methods of providing interpreting

Interpreting may be provided through various methods, including hiring bilingual staff and staff interpreters, contracting for interpreters, using telephonic/ video conferencing interpreting services, and using community volunteers.

multilingual

A term describing a person who has some degree of proficiency in two or more languages. A high level of bilingualism or multilingualism is the most basic of the qualifications of a competent interpreter, but by itself does not insure the ability to interpret.

national origin discrimination Violation of the 'national origin' clause of Title VI of the Civil Rights Act of 1964, which states that "no person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, or be denied benefits of, or be subjected to discrimination under any program or activity receiving federal assistance." *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (2003) [**http://www.hhs.gov/ocr/lep/revisedlep.html**] details how national origin discrimination may be avoided through the use of qualified interpreters and translators.

Office for Civil Rights (OCR) OCR has responsibility to oversee Title VI implementation for HHS. It provides technical assistance to recipients of federal funds and can also initiate investigations or respond to complaints of discrimination pursuant to Title VI. See also **Title VI**.

on-site interpreting Interpreting done by an interpreter who is directly in the presence of the speakers. Also called *face-to-face interpreting*. See also **remote interpreting, telephone interpreting**

pre-session A brief meeting held before an appointment, between the provider and the interpreter or sometimes between the interpreter and the patient, in which the participants establish an understanding of how communication should be conducted, discuss the health issues at hand, relevant cultural issues, or other topics concerning the appointment.

proficiency Thorough language competence in a given setting derived from training and practice. In health care settings, proficiency requires knowledge of medical terminology in both languages.

professional interpreter An individual with appropriate training and experience who is able to interpret with consistency and accuracy and who adheres to a code of professional ethics. See also **interpreter**, **ad hoc interpreter**.

register	The level of formality or complexity of language a person uses, or a speaker's linguistic features of pronunciation, vocabulary and grammar that contribute to the speaker's perceived level of education or social class.[68] A speaker's choice of register may be adapted to a particular topic, the parties spoken to, and the perceived formality of the situation.[69] For example, in interpreting and translation, in some languages, the vocabulary used for Western medical concepts may only be familiar to people with a university education, but not to others, even though the vocabulary exists in that language.
relay interpreting	An interpreting process in which two individuals attempting a conversation communicate through two interpreters, each of whom speaks only one of the two languages required as well as a common third language. An example of this would be interpreting Quechua into Spanish, which in turn is interpreted into English.
remote interpreting	Interpreting provided by an interpreter who is not in the presence of the speakers, e.g., interpreting via telephone or videoconferencing. See also **telephone interpreting**, **video interpreting**, **on-site interpreting**.
sight translation	Translation of a written document into spoken language, on the spot. An interpreter reads a document written in one language and simultaneously interprets it into a second language.
simultaneous interpreting	Converting a speaker message into another language while the speaker continues to speak or sign. For example, the United Nations utilizes simultaneous interpreting via headphones. See also, contra, **consecutive interpreting**.
sign(ed) language	Language of hand gestures and symbols used for communication with deaf and hearing-impaired people.
source language	The language of a speaker who is being interpreted. See also, contra, **target language**.

summarizing	A limited interpretation that excludes all or most details focusing only on the principal points of the interpreted speech — not a full interpretation. Summarizing does not comply with codes of ethics that require full interpretation.
summary interpretation	See **summarizing**.
target language	The language into which an interpreter is interpreting at any given moment. See also **source language**.
telephone/telephonic interpreting	Interpreting carried out remotely, with the interpreter connected by telephone to the principal parties, typically provided through a speaker-phone or headsets. In health care settings, the principal parties, e.g., health care provider/clinician and patient, are normally in the same room, but telephone interpreting can be used to serve individuals who are also connected to each other only by telephone. See also **remote interpreting**.
Title VI of the Civil Rights Act of 1964	This federal law states "no person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, or be denied benefits of, or be subjected to discrimination under any program or activity receiving federal assistance."[70] The Supreme Court and federal agencies have determined that recipients of federal funds must ensure that LEP individuals have meaningful access to their programs and services. In most health care settings, HHS' Office for Civil Rights oversees implementation of Title VI.
trained interpreter	A professional with formal training, accreditation or certification who has developed the knowledge and skills for competent interpreting. In addition to demonstrating fluency in English and a second language, a trained interpreter is bound by a professional code of ethics, culturally competent, capable of delivering accurate and timely messages in two languages and knowledgeable of specialized terminology.

translation	The conversion of a written text into a corresponding written text in a different language. Within the language professions, **translation** is distinguished from **interpreting** according to whether the message is produced *in writing* or *orally* (or manually). In popular usage, the terms "translator" and "translation" are frequently used for conversion of either oral or written communications.
translator	A person who translates written texts. See also **translation**, **interpreter**.
transparency	The principle that during the encounter the interpreter informs all parties of any action he or she takes, including speaking for him- or herself, outside of direct interpreting.[71] Whenever the interpreter speaks directly to either party in either language, the interpreter must subsequently interpret both his/her own speech and that of the party spoken to, for the benefit of those present who do not understand the language used.
treating team	All health care providers involved in the care of a particular patient within a single facility.
TTY relay	A service enabling telephone communication between TTY/TDD customers (who are usually deaf or hard of hearing) and hearing people.
unidirectional interpreting	Interpretation from only one source language (usually found in conference interpreting where participants' responses are not interpreted).
video conferencing	Remote conference by televideo technology. See also **remote interpreting**, **video interpreting**.

video interpreting

Interpreting carried out remotely, using a video camera that enables an interpreter in a remote location to both see and hear the parties for whom he/she is interpreting via a TV monitor. The interpretation is relayed to the principal parties by speakerphone or through headsets. Two-way interactive television can also be used, so that the other parties can interact with the interpreter as if face to face. See also **remote interpreting**.

visual language

Forms of communication used by interpreters for the deaf, including American Sign Language (ASL), Quebecois French (LSQ) and other sign language variants in other parts of the world (*e.g.*, British, Spanish, French, Mexican), transliterated English (word by word interpretation from English into visual language), lip reading, and tactile interpretation. Note that sign languages for the deaf are unique languages with their own syntax and are not signed versions of English or other spoken languages (CHIA).

working language

A language an interpreter uses professionally; a language into and/or out of which an interpreter interprets. See also **language combination**.

A

Appendix A. Statement of Principles

This Statement of Principles springs from the work of numerous national organizations over the past six months to develop an agenda to improve policies and funding for access to health care for individuals with limited English proficiency (LEP). Participants in this effort included health care provider organizations, advocates, language companies, interpreters and interpreter organizations, and accrediting organizations.

Language Access in Health Care Statement of Principles

To guide the way toward a world in which language barriers do not affect health outcomes, a diverse group of interested stakeholders developed these principles. The intent is to provide a broad framework to inform efforts to improve health care delivered to limited English proficient individuals.

Nearly 47 million people — 18 percent of the U.S. population — speak a language other than English at home.[72] The 2000 census documented that over 28 percent of all Spanish speakers, 22.5 percent of Asian and Pacific Island language speakers, and 13 percent of Indo-European language speakers speak English "not well" or "not at all."[73] Estimates of the number of people with limited English proficiency (LEP) range from a low of about 11 million, or 4.2 percent of the U.S. population — who speak English "not well" or "not at all" — to over 21 million people, or 8.1 percent of the U.S. population — if one includes those who speak English less than "very well."[74]

As demographic trends continue to evolve,[75] the prevalence, composition and geographic distribution of languages spoken will continue to be fluid and necessitate the ongoing assessment of language needs. Multilingualism is spreading rapidly, in rural states and counties as well as urban environments.[76] Between 1990 and 2000, fifteen states experienced more than 100 percent growth in their LEP populations — Arkansas, Colorado, Georgia, Idaho, Kansas, Kentucky, Minnesota, Nebraska, Nevada, North Carolina, Oregon, South Carolina, Tennessee, Utah and Washington.[77]

As the number of non-English speaking residents continues to increase, so does the demand for English-as-a-Second-Language (ESL) classes. This heightened demand has led to long waiting lists for ESL classes in many parts of the country.[78] For example, in New York State, one million immigrants need ESL classes, but there are seats for only 50,000 while in Massachusetts, less than half of those who applied for English classes were able to enroll.[79]

Research documents how the lack of language services creates a barrier to and diminishes the quality of health care for limited English proficient individuals.[80] Over one quarter of LEP patients who needed, but did not get, an interpreter reported they did not understand their medication instructions, compared with only 2 percent of those who did not need an interpreter and those who needed and received one.[81] Language barriers also impact access to care – non-English speaking patients are less likely to

use primary and preventive care and public health services and are more likely to use emergency rooms. Once at the emergency room, they receive far fewer services than do English speaking patients.[82] Language access is one aspect of cultural competence that is essential to quality care for LEP populations.

Health care providers from across the country have reported language difficulties and inadequate funding of language services to be major barriers to LEP individuals' access to health care and a serious threat to the quality of the care they receive.[83] The increasing diversity of the country only amplifies the challenge for health care providers,[84] who must determine which language services are most appropriate based on their setting, type and size; the frequency of contact with LEP patients; and the variety of languages encountered. But without adequate attention and resources being applied to address the problem, the health care system cannot hope to meet the challenge of affording LEP individuals appropriate access to quality health care.

Those endorsing this document view it as an inseparable whole that cannot legitimately be divided into individual parts. Each of the principles articulated here derives its vitality from its context among the others, and any effort to single out one or another would therefore undercut the structural integrity of the entire framework.[85] The principles are as follows:

1. Effective communication between health care providers and patients is essential to facilitating access to care, reducing health disparities and medical errors, and assuring a patient's ability to adhere to treatment plans.
2. Competent health care language services are essential elements of an effective public health and health care delivery system in a pluralistic society.
3. The responsibility to fund language services for LEP individuals in health care settings is a societal one that cannot fairly be visited upon any one segment of the public health or health care community.
4. Federal, state and local governments and health care insurers should establish and fund mechanisms through which appropriate language services are available where and when they are needed.
5. Because it is important for providing all patients the environment most conducive to positive health outcomes, linguistic diversity in the health care workforce should be encouraged, especially for individuals in direct patient contact positions.
6. All members of the health care community should continue to educate their staff and constituents about LEP issues and help them identify resources to improve access to quality care for LEP patients.
7. Access to English as a Second Language instruction is an additional mechanism for eliminating the language barriers that impede access to health care and should be made available on a timely basis to meet the needs of LEP individuals, including LEP health care workers.

8. Quality improvement processes should assess the adequacy of language services provided when evaluating the care of LEP patients, particularly with respect to outcome disparities and medical errors.
9. Mechanisms should be developed to establish the competency of those providing language services, including interpreters, translators and bilingual staff/clinicians.
10. Continued efforts to improve primary language data collection are essential to enhance both services for, and research identifying the needs of, the LEP population.
11. Language services in health care settings must be available as a matter of course, and all stakeholders – including government agencies that fund, administer or oversee health care programs – must be accountable for providing or facilitating the provision of those services.

Endorsing Organizations[86]

American Academy of Family Physicians

American Academy of Pediatrics

American Association of Physicians of Indian Origin

American Civil Liberties Union

American College of Physicians

American Counseling Association

American Hospital Association

American Medical Student Association

Asian American Justice Center

Asian Pacific Islander American Health Forum

American Psychological Association

Association of Asian Pacific Community Health Organizations

Association of Community Organizations for Reform Now

Association of Language Companies

Association of University Centers on Disabilities

Bazelon Center for Mental Health Law

California Association of Public Hospitals and Health Systems

California Health Care Safety Net Institute

California Healthcare Association

California Healthcare Interpreting Association

Catholic Charities USA

Catholic Health Association

Center for Medicare Advocacy

Children's Defense Fund

Center on Budget and Policy Priorities

Center on Disability and Health

Cuban American National Council

District of Columbia Language Access Coalition

District of Columbia Primary Care Association

Families USA

Family Voices

Greater New York Hospital Association

HIV Medicine Association

Institute for Reproductive Health Access

Joint Commission on the Accreditation of Health Care

La Clinica del Pueblo

Latino Caucus, American Public Health Association

Latino Coalition for a Healthy California

Massachusetts Medical Interpreters Association

Medicare Rights Center

Mexican American Legal Defense and Educational Fund

Migrant Legal Action Program

National Asian American Pacific Islander Mental Health Association

National Asian Pacific American Families Against Substance Abuse

National Asian Pacific American Legal Consortium

National Asian Pacific American Women's Forum

National Association of Community Health Centers

National Association of Mental Health Planning and Advisory Councils

National Association of Public Hospitals and Health Systems

National Association of Social Workers

National Association of Vietnamese American Service Agencies

National Center for Law and Economic Justice

National Council of La Raza

National Council on Interpreting in Health Care

National Family Planning and Reproductive Health Association

National Health Law Program

National Immigration Law Center

National Hispanic Medical Association

National Latina Institute for Reproductive Health

National Medical Association

National Mental Health Association

National Partnership for Women and Families

National Respite Coalition

National Senior Citizens Law Center

National Women's Law Center

Northern Virginia Area Health Education Center

Physicians for Human Rights

Presbyterian Church (U.S.A.) Washington Office

Service Employees International Union

Society of General Internal Medicine

Summit Health Institute for Research and Education

USAction

B

Appendix B. Federal Laws and Policies to Ensure Access to Health Care Services for People with Limited English Proficiency

Federal Laws and Policies to Ensure Access to Health Care Services for People with Limited English Proficiency[87]

This information, presented in a question-and-answer format, intends to provide a brief overview of the legal requirements regarding language access. In addition to legal requirements, health care providers often choose to provide language access to ensure that LEP patients receive access to the same quality of health care as English-speaking patients.

1. **Is there a federal requirement that health care providers offer interpreters to individuals who do not speak English well?**

   Yes. In 1964, Congress passed Title VI of the Civil Rights Act. This is a civil rights law that prohibits discrimination. Its purpose is to ensure that federal money is not used to support health care providers who discriminate on the basis of race, color, or national origin.[88] Title VI says:

   > *No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.*[89]

   The federal Department of Health and Human Services (HHS) and the courts have applied this statute to protect national origin minorities who do not speak English well. Thus, recipients of federal funding must take reasonable steps to ensure that people with limited English proficiency (LEP) have meaningful access to their programs and services.

2. **What if a provider unintentionally discriminates against individuals?**

   HHS issued regulations to implement Title VI that reiterate the statute and extend Title VI beyond the prohibition of intentional discrimination. They prohibit federal fund recipients from:

   - using criteria or methods of administration which have the *effect* of discriminating because of race, color or national origin;
   - restricting the enjoyment of any advantage or privilege enjoyed by others receiving services through the same program;
   - providing services or benefits to an individual that are different, or provided in a different way, from those provided to others;
   - treating an individual differently from others in determining admission, enrollment, eligibility, or other requirement to receive services.[90]

Through these regulations, the HHS Office for Civil Rights (OCR) can initiate investigations or respond to complaints of discrimination.

3. Who is covered by Title VI?

The obligations under Title VI and HHS' regulations apply broadly to any "program or activity" that receives federal funding, either directly or indirectly (through a contract or subcontract, for example), and without regard to the amount of funds received.[91] This includes payment for services provided to Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) enrollees. Thus, in the health care context, this includes virtually all:

- hospitals;
- doctor's offices;[92]
- nursing homes;
- managed care organizations;
- state Medicaid agencies;
- home health agencies;
- health service providers; and
- social service organizations.

Further, the Title VI protections extend to all of the operations of the organization or individual, not just that part that received the federal funds.[93]

4. Why has so much discussion recently focused on language access?

The number of languages spoken in the United States is increasing significantly. According to the 2000 Census, over 21 million individuals speak English less than "very well." Many states saw significant increases in their LEP populations. Recent federal activities focusing on improving language access have also increased discussion on the issue. These activities include a presidential "Executive Order" (EO) entitled *Improving Access to Services for Persons with Limited English Proficiency*,[94] publication of guidance on language access by many federal departments, and release of the "CLAS Standards" (Standards for Culturally and Linguistically Appropriate Services in health care) by the Office of Minority Health.[95] The Executive Order affects all "federally conducted and federally assisted programs and activities." This includes health care providers that receive federal funds such as Medicare, Medicaid and SCHIP. The EO asks each federal agency to draft a guidance specially tailored to its federal fund recipients and applies Title VI to the federal departments and agencies themselves so that they have to administer their programs in a non-discriminatory way.

The current Administration has reaffirmed its commitment to the Executive Order and has continued activities to ensure its implementation.

5. How does a health care provider know what it should do to provide language services?

The Department of Justice, which coordinates the federal government's Title VI oversight, announced four factors for federal fund recipients to use to determine what steps they should take to assist LEP persons:[96]

- *The number or proportion of LEP individuals served or encountered.*[97]
- *The frequency of contact with the program.* If LEP individuals access the program on a daily basis, a recipient has greater duties than if contact is infrequent.
- *The nature and importance of the program to beneficiaries.* More steps must be taken if a denial or delay of services may have critical implications for daily life (e.g. hospitals, schools) than in programs that are not as crucial (e.g. theaters, zoos).
- *The resources available and cost considerations.* A small recipient with limited resources may not have to take the same steps as a larger recipient in programs where the numbers of LEP persons are limited. Costs are a legitimate consideration in identifying the reasonableness of particular language assistance measures.[98]

In balancing these factors, providers should address the appropriate mix of written and oral language assistance, including which documents must be translated, when oral interpretation is needed, and whether such services must be immediately available.[99]

6. Are there specific guidelines for health care providers?

Yes. On August 8, 2003, the HHS Office for Civil Rights (OCR) issued guidance for its recipients of federal funds, which include health care providers.[100] This guidance does not impose any new requirements but merely brings together all of OCR's policies for overseeing Title VI since 1965.

7. How does OCR determine if a health care provider is discriminating?

OCR looks at the totality of the circumstances in each case. Four factors will be assessed: (1) the number or proportion of LEP individuals eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs. According to HHS, after the four factors have been applied, fund recipients can decide what reasonable steps, if any, they should take to ensure meaningful access. Fund recipients may choose to develop a written implementation plan as a means of documenting compliance with Title VI.

8. How should a provider offer oral interpretation services?

The HHS Guidance describes various options available for oral language assistance, including the use of bilingual staff, staff interpreters, contracting for interpreters, using telephone interpreter lines,[101] and using community volunteers. It stresses that interpreters need to be competent, though not necessarily formally certified. The Guidance allows the use of family members and friends as interpreters

but clearly states that an LEP person may not be required to use a family member or friend to interpret. Moreover, HHS says recipients should make the LEP person aware that he or she has the "option" of having the recipient provide an interpreter for him/her without charge.

"Extra caution" should be taken when the LEP person chooses to use a minor to interpret. Recipients are asked to verify and monitor the competence and appropriateness of using the family member of friend to interpret, particularly in situations involving administrative hearings; child or adult protective investigations; life, health, safety or access to important benefits; or when credibility and accuracy are important to protect the individual.

9. When should a provider translate written materials?

It depends on the relevant circumstances of each provider based on the factors listed above. After the four factors have been applied, recipients can decide what reasonable steps, if any, they should take to ensure meaningful access. Recipients could develop a written implementation plan as a means of documenting compliance with Title VI. If so, the following five elements are suggested when designing such a plan:

- Identifying LEP individuals who need language assistance, using for example, language identification cards.
- Describing language assistance measures, such as the types of language services available, how staff can obtain these services and respond to LEP persons; how competency of language services can be ensured.
- Training staff to know about LEP policies and procedures and how to work effectively with in-person and telephone interpreters.
- Providing notice to LEP person through, for example, posting signs in intake areas and other entry points, providing information in outreach brochures, working with community groups, using a telephone voice mail menu, providing notices in local non-English media sources, and making presentations in community settings.
- Monitoring and updating the LEP plan, considering changes in demographics, types of services, and other factors.[102]

OCR will evaluate a provider's efforts on a case-by-case basis. For the translation of written materials, the Guidance designates "safe harbors" that, if met, will provide strong evidence of compliance.[103]

10. What are the costs and benefits of providing language services?

The federal Office of Management and Budget (OMB) reported to Congress:

> *Almost all individuals, LEP and non-LEP, need to access the health care system at multiple points in their lives. Making these interactions more effective and more accessible for LEP*

persons may result in a multitude of benefits, including: increased patient satisfaction, decreased medical costs, improved heath, sufficient patient confidentiality in medical procedures, and true informed consent.[104]

The OMB was unable to evaluate the actual costs due to insufficient information. However, using data from emergency room and inpatient hospital visits and outpatient physician and dental visits, it estimated that language services would add an extra 0.5 percent to the average cost per visit.[105]

11. How can health care providers pay for language services?

On August 31, 2000, the Health Care Financing Administration (now Centers for Medicare & Medicaid Services or CMS) stated that federal Medicaid and SCHIP funds can be used for language activities and services.[106] States can thus submit the costs incurred by themselves or health care providers serving Medicaid and SCHIP enrollees to the federal government for partial reimbursement.

12. If my state draws down Medicaid/ SCHIP funds, to whom can language services be provided?

States can only receive federal reimbursement for language services provided to Medicaid and SCHIP enrollees (or applicants who need assistance in applying). Depending on how your state structures the reimbursement, it can be available to all providers, including community health centers, managed care organizations and hospitals. Some states have limited the reimbursement to "fee-for-service" providers. Many states currently set their reimbursement rates for hospitals, clinics and managed care organizations to include the costs of language services as part of the entity's overhead or administrative costs. But a state could allow all providers to submit for reimbursement.

13. What if my state has an English-only law — does Title VI still apply?

Yes. As noted by OCR's guidance, the federal law applies regardless of whether your state law makes English its only recognized language (because federal law "preempts" any conflicting state law).[107] Since Title VI applies to the receipt of federal funds, a health care provider cannot forego his/her obligations under federal law. In addition, your state's English-only laws may have a specific exemption for health care/social services and/or may only apply to government activities.

14. Where can I get more information?

The federal government has launched a website called "Let Everyone Participate," **http://www.lep.gov**. In addition to tracking federal activities, the website offers direct assistance to federal fund recipients and advocates. For example, fund recipients can download "I Speak" cards that allow LEP persons to identify their primary language.

C

Appendix C. Medicaid/SCHIP Reimbursement for Language Services

Medicaid/SCHIP Reimbursement Models for Language Services[108]

In 2000, the Centers for Medicare & Medicaid Services (CMS) reminded states that they could include language services as an administrative or optional covered service in their Medicaid and State Children's Health Insurance Programs, and thus directly reimburse providers for the costs of these services for program enrollees. Yet only a handful of states are directly reimbursing providers for language services. Currently, 11 states are providing reimbursement – Hawaii, Idaho, Kansas, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah, Vermont and Washington. Virginia anticipates beginning a pilot project during the spring of 2006. And Texas recently enacted legislation requiring a pilot program that is anticipated to begin later this year.

The following page outlines existing state mechanisms for directly reimbursing providers for language services for Medicaid and SCHIP enrollees.[109] For more information on funding for Medicaid and SCHIP services, see *How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and SCHIP Enrollees?*[110] While only a few states currently provide reimbursement, the examples below can help you identify promising ways to develop a campaign and reimbursement mechanism that will meet your state's reimbursement needs and goals.

State	For which Medicaid and SCHIP enrollees does the state pay for language services?	Which Medicaid and SCHIP providers can submit for reimburse-ment?	Who does the state reimburse?	How much does the state pay for language services provided to Medicaid/SCHIP enrollees?	How does the state claim its federal share — as a service or admin-istrative expense?	What percentage of the state's costs does the federal government pay (FY 2006)?[112]
HI	Fee-for-service (FFS)[113]	FFS	language agencies[114]	$36/hour (in 15 min. increments)	Service	Medicaid (MA) — 57.55% SCHIP – 70.29%
ID	FFS	FFS	providers	$12.16/hour	Service	MA — 70.36% SCHIP — 79.25%
KS	Managed care	Not applicable (state pays for language line)	EDS (fiscal agent)	Spanish — $1.10/minute; other languages — $2.04/minute	Admin	50%
MA	FFS	hospitals & psychiatric facilities	hospitals & psychiatric facilities	Determined by Medicaid agency[115]	Unknown	50%
ME	FFS	FFS	providers	Reasonable costs reimbursed	Service	MA — 63.27% SCHIP — 74.29%
MN	FFS	FFS	providers	lesser of $12.50/ 15 min or usual and customary fee	Admin	50%
MT	all Medicaid	all[116]	interpreters	lesser of $6.25/ 15 minutes or usual and customary fee	Admin	50%
NH	FFS	FFS	interpreters (who are Medicaid providers)	$15/hour $2.25/15 min after first hour	Admin	50%
TX	Undecided	Undecided	Undecided	Undecided	Undecided	Unknown
UT	FFS	FFS	language agencies	$22/hour (phone) $39/hour (in-person)	Service	MA — 70.14% SCHIP — 79.10%
VA	FFS	FFS	Area Health Education Center & three public health departments	Reasonable costs reimbursed	Admin	50%
VT	All	All	language agency	$15/15 min. increments	Admin	50%
WA	All	public entities	public entities	50% allowable expenses	Admin	50%
WA	All	non-public entities	brokers; interpreters & language agencies	Brokers receive an administrative fee Interpreters/ language agencies receive $32/hour	Admin	50%

Hawaii[117]

The state contracts with two language service organizations to provide interpreters. The eligible enrollees are Medicaid fee-for-service patients or SCHIP-enrolled children with disabilities. The state pays the language service agency a rate of $9 per 15 minutes. If an interpreter is needed for more than 1½ hours, a report must be submitted stating the reason for the extended time. Interpreters who are staff or bilingual providers are not reimbursed.

Interpreters are allowed to charge for travel, waiting time, and parking. The state has guidelines on billing procedures and utilization, and language service organizations are expected to monitor quality and assess the qualifications of the interpreters they hire. The state spends approximately $144,000 per year on interpreter services for approximately 2570 visits (approximately $56 per visit). Hawaii receives reimbursement for the interpreter services as a "covered service" (similar to an office visit or other service covered by the state's Medicaid plan). The state receives federal reimbursement of approximately 57 percent for Medicaid patients and 70 percent for SCHIP patients.

The costs of providing interpreters for inpatient hospital stays are included in hospitals' existing payment rates; separate reimbursement is not allowed. QUEST, the state's Medicaid managed care program, includes specific funding in its capitated rates for enabling/translation services (based on volume and claims submission data).

Idaho

Idaho began reimbursing providers for the costs of interpreters prior to 1990. The state reimburses for interpreters provided to fee-for-service enrollees and those participating in the Primary Care Case Management program. Providers must hire interpreters and then submit claims for reimbursement. Providers must use independent interpreters; providers can only submit claims for reimbursement for services provided by members of their staff if they can document that the staff are not receiving any other form of wages or salary during the period of time when they are interpreting. No training or certification requirements for interpreters currently exist.

Hospitals may not submit claims for reimbursement for language services provided during inpatient hospital stays. The costs of language services are considered part of the facilities' overhead and administrative costs.

Idaho reimburses the costs of language interpretation at a rate of $12.16 per hour (this is the same rate for sign language interpreters). For FY 2004,[118] the state spent $37,621 on language services for 4,137 encounters. For the first half of FY 2005, the state spent $28,334 for 2,808 encounters.

Kansas

In 2003, Kansas began offering Medicaid managed care health care providers access to a telephone interpreter/language line. The service is provided to primary care providers (for example, individual doctors and group

practices, rural health centers, federally qualified health centers, Indian health centers, advanced registered nurse practitioners, and nurse widwives) and specialists.

The state began providing this service in part because of federal Medicaid managed care regulations and in response to results from a provider survey. The survey results — collected from 87 providers — identified that Spanish is the most frequently spoken language requiring interpretation services. Other languages are less frequently encountered. Nineteen providers reported that they never needed access to an interpreter. Twenty-five providers reported needing an interpreter 1–10 times per month and seven providers responded they needed an interpreter over 100 times per month.

The state's Medicaid fiscal agent, EDS, administers the language line. The provider calls into the Managed Care Enrollment Center (MCEC) and provides a password to the customer service rep (CSR). The CSR then connects to the language line and the provider uses their services. The bill is returned to the MCEC who then passes it on to the state Medicaid agency for reimbursement. The state utilizes two language lines — Propio Language Services for Spanish interpretation (charging $1.10/minute) and Certified Languages International for other languages ($2.04/minute).

From September 2003 through June 2004, Kansas spent $28,736.26 on the language line. Recently, however, the state has been averaging payments of $4,000 per month.

Maine

The state reimburses providers for the costs of interpreters provided to Medicaid and SCHIP enrollees. The selection of the interpreter is left up to the provider. Providers are encouraged to use local and more cost-effective resources first, and telephone interpretation services only as a last resort. Providers then bill the state for the service, in the same way they would bill for a medical visit, but using a state-established interpreter billing code. When using telephone interpretation services, providers use a separate billing code and must submit the invoice with the claim for reimbursement.

The provider must include a statement of verification in the patient's record documenting the date and time of interpretation, its duration, and the cost of providing the service. The state reimburses the provider for 15-minute increments. The reimbursement does not include an interpreter's wait time; travel time is not specifically addressed although its policy states that it will not reimburse an interpreter who is transporting an enrollee. The state no longer has an established reimbursement rate but reimburses "reasonable costs." The provider must ensure that interpreters protect patient confidentiality and have read and signed a code of ethics. The state provides a sample code of ethics as an appendix to its Medical Assistance Manual.

The state is explicit that family members and friends should not be used as paid interpreters. A family member or friend may only be used as an interpreter if:

1) the patient requests it; 2) the use of that person will not jeopardize provider-patient communication or patient confidentiality; and 3) the patient is informed that an interpreter is available at no charge.

Hospitals (for language services provided during an inpatient stay), private non-medical institutions, nursing facilities, and intermediate care facilities for the mentally retarded may not bill separately for interpreter costs. Rather, costs for interpreters for these providers are included in providers' payment rates. (*MaineCare Benefits Manual*, formerly *Medical Assistance Manual*, Chapter 101, 1.06-3.)

Massachusetts

Currently, Massachusetts' reimbursement for language services in Medicaid is limited to hospital emergency rooms and inpatient psychiatric institutions. No direct reimbursement is provided for other inpatient or outpatient services.

Massachusetts has been a leader in the development and provision of language services in clinical health settings. As part of the state's Determination of Need process, whenever a provider seeks to add or expand services or transfer ownership, it must reassess health care needs in the community and respond accordingly. Since 1989, most hospitals have submitted plans for providing interpreter services as part of this process. Through this process, over 50 of the state's 80 hospitals have addressed the provision of interpreter services, training for staff, and tracking of services.

In April 2000, the legislature took additional steps to address the need for competent emergency room interpreter services when it passed Chapter 66 of the Acts of 2000, "An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Care Services." This law mandates that "every acute care hospital . . . shall provide competent interpreter services in connection with all emergency room services provided to every non-English-speaker who is a patient or who seeks appropriate emergency care or treatment." The law also applies to hospitals providing acute psychiatric services. The state attorney general is authorized to enforce the law, and individuals who are denied emergency services because of the lack of interpreters are also given legal standing to enforce their rights.

The FY 2005 state budget included an appropriation of $1.1 million to reimburse hospitals and acute psychiatric facilities for the costs of language services. The Division of Medical Assistance is making "supplemental payments" to "qualifying" hospitals for interpreter services provided at hospital emergency departments, acute psychiatric facilities located within acute hospitals, and private psychiatric hospitals. The distribution is done based on an "equity formula" comparing expenses submitted by each qualifying hospital to the total expenses submitted by all qualifying hospitals. In 2003, Massachusetts received approval of three State Plan Amendments (one each for psychiatric hospitals, and inpatient and outpatient acute-care hospital care) to obtain federal reimbursement.

In addition, the state's Medicaid agency considers interpreter costs in its DSH (Disproportionate Share Hospital) distribution formula. Medical interpreter costs are identified by the hospitals on their cost reports, which are used to determine unreimbursed costs for DSH purposes. Distribution of DSH funds is then based on these unreimbursed costs. For purposes of its Uncompensated Care Pool (UCP), Massachusetts allows hospitals to include the costs of language services in the base costs used to develop Medicaid rates and the UCP cost-to-charge ratio.

Website: **http://www.state.ma.us/dph/omh/interp/interpreter.htm**

Minnesota

In 2001, Minnesota began drawing down federal matching funds for language interpreter services for Medicaid and SCHIP fee-for-service and managed care enrollees. All fee-for-service providers can submit for reimbursement for outpatient services. The state's managed care capitation rate includes the costs of language services.

Under Minnesota's provisions, providers must both arrange and pay for interpretation services and then submit for reimbursement. The state established a new billing code and pays either $12.50 or the "usual and customary charge" per 15-minute interval, whichever is less.

Providers may only bill for interpreter services offered in conjunction with an otherwise covered service. For example, a physician may bill for interpreter services for the entire time a patient spends with the physician or nurse, and when undergoing tests, but not for appointment scheduling or interpreting printed materials. Providers serving managed care enrollees must bill the managed care plan. The managed care plan has the responsibility, pursuant to its contract with the state, to ensure language access; these costs are included in its payment rate.

Hospitals may obtain reimbursement for interpreter costs provided for outpatient care. The costs of language services in inpatient settings are bundled in the hospital payment rate. This payment rate, called the DRG (Diagnosis Related Group), does include a differential to address the costs of language services. When the DRG rates are set by the state, it considers historical data and makes rate adjustments. Although there are not specific adjustments for language services; these costs are generally assumed to be included in the hospital's overhead costs. But because the state bases the DRG on each hospital's own expenses (rather than peer groups or one DRG for the entire state), if a particular hospital has high language services costs, these should be included in the hospital's overall expenses, resulting in a higher DRG rate to compensate.

In FY 2004,[119] the state spent $1,339.000 on language services for fee-for-service Medicaid enrollees. Approximately 12,000 distinct recipients received interpreter services for a total of approximately 35,000 encounters.

Website: **http://www.dhs.state.mn.us**

Montana[120]

Montana began reimbursing interpreters in 1999 following an investigation by the federal HHS Office for Civil Rights. Montana pays for interpreter services provided to eligible Medicaid recipients (both fee-for-service and those participating in the Primary Care Case Management program) if the medical service is medically necessary and a covered service. The interpretation must be face-to-face; no reimbursement is available for telephone interpretation services. The interpreter must submit an Invoice/Verification form signed by the interpreter and provider for each service provided; Montana then reimburses the interpreter directly. Reimbursement is not available if the interpreter is a paid employee of the provider and provides interpretation services in the employer's place of business, or is a member of the patient's family.

The reimbursement rate is the lesser of $6.25 per 15-minute increment or the interpreter's usual and customary charge. Interpreters may not bill for travel or waiting time, expenses, or for "no-show" appointments. The interpreter can bill for up to one 15-minute increment of interpreter time outside the Medicaid provider's office (*i.e.*, at the Medicaid client's home or pharmacy) for each separate interpreter service performed per day. This time is specifically used for the interpreter to exchange information and give instructions to the Medicaid client regarding medication use.

The state does not have any interpreter certification requirements. Thus it is the responsibility of the provider to determine the interpreter's competency. While a state referral service operates for sign language interpreters, no equivalent exists for foreign language interpreters.

New Hampshire

New Hampshire has had policies to reimburse sign language and foreign language interpreters since the 1980's. While the state initially reimbursed for interpreters as a covered service, it currently reimburses interpreters as an administrative expense.[121]

Currently, interpreters are required to enroll as Medicaid providers, although through an abbreviated process since they do not provide medical services. Each interpreter has a provider identification number and can bill the state directly for services provided. The state contracts with EDS — a company that oversees all provider enrollment and billing — which also oversees interpreter enrollment. The state reimburses interpreters $15 for the first hour, and $2.25 for each subsequent quarter hour ($25/hour for sign language interpreters).

Interpreters can bill directly or can work for an organization that coordinates interpreter services. Each interpreter, however, must individually enroll as a Medicaid provider regardless of who bills for reimbursement. Currently, interpreters (or language services organizations) can submit claims for reimbursement for language services only for clients of fee-for-service providers; interpreters cannot submit claims for hospital (inpatient or outpatient services) and community health center clients. At the

present time, the state has 76 interpreters enrolled as Medicaid providers; training programs funded in part by the state have helped increase this number. The state is also examining ways to lessen the administrative burdens on interpreters and increase the availability of Medicaid interpreters.

In FY 2003,[122] the state spent $5,870 on interpreters. Eighty-two Medicaid recipients received interpreter services for a total of 310 encounters. In FY 2004, the state spent $9,017 on 157 Medicaid recipients for 605 encounters.

Texas

In the Spring of 2005, Texas enacted legislation establishing a Medicaid pilot project for reimbursement for language services.[123] The project will initially involve five hospital districts. The Health and Human Services Commission is tasked with developing the project and is in its initial planning stages.

The pilot project will be financed through intergovernmental transfers from the participating hospital districts matched with federal Medicaid funds. The program will be evaluated by 2007 and will expire on September 1, 2009, if no further action is taken.

Utah

Utah covers medical interpreter services as a covered service; in FY 2005, the state will receive a 72 percent federal matching rate for Medicaid interpretations and 80 percent for SCHIP expenditures. The state pays for interpreters when three criteria are met: 1) the client is eligible for a federal or state medical assistance program (including Medicaid and SCHIP); 2) the client receives services from a fee-for-service provider; and 3) the health care service needed is covered by the medical program for which the client is eligible.

The state contracts with five language service organizations (covering 27 languages) to provide in-person and telephone interpreter services to fee-for-service Medicaid, SCHIP, and medically indigent program patients. The health care provider must call the language service organization to arrange for the service. The language service organizations are reimbursed by the state an average of $22/visit for phone interpretation and $35/hour for in-person interpretation, with a one-hour minimum. The state will enter into new contracts for language services in 2006. If the language agencies do not provide the needed language, the provider may use a telephone interpretation service.

Providers cannot bill Medicaid directly, and they do not receive any rate enhancements for being bilingual or having interpreters on staff. Rather, interpreters bill the Medicaid agency. Hospitals can utilize Medicaid-funded interpreters for fee-for-service Medicaid enrollees for all services covered by Medicaid, both inpatient and outpatient. Hospitals may not use the Medicaid language services for Medicaid managed care enrollees. For enrollees in managed care, Utah requires health plans to provide interpretation services for their patients as

part of the contract agreements. For services covered by Medicaid but not the health plan,[124] the state will pay for interpreters.

In FY 2003, Utah spent $46,700 for interpretation although the amount nearly doubled in FY 2004 to $87,500. (Utah's costs for sign language interpretation were approximately $8,000 in FY 2003 and $13,000 for FY 2004 although these figures include non-Medicaid expenses as well).

Website: **http://health.utah.gov/medicaid/html/interpreter.html**

Vermont

Vermont began reimbursing for interpreters provided to Medicaid clients a few years ago. Medicaid providers hire interpreters and can submit the costs of interpreters along with the medical claim. Reimbursement is limited to $15 for each 15-minute increment. The state does not reimburse for travel or waiting time. Further, reimbursement is not allowed for bilingual staff that serves as interpreters.

While providers may hire any interpreter, services are primarily provided by one language agency. The state Agency for Health Services has a contract with the language agency to meet its interpretation needs and informs providers of this agency. However, providers must make their own arrangements with the agency. The agency also has a statewide telephonic interpretation contract to provide interpreters in rural areas but providers who use telephonic interpretation cannot currently submit for Medicaid reimbursement.

Virginia

Virginia anticipates beginning a pilot project for reimbursement shortly. Senate Joint Resolution 122 (2004) directed the Department of Medical Assistance Services (DMAS) to seek reimbursement for translation and interpreter services from the Centers for Medicare & Medicaid Services. The state will submit claims to CMS as part of its administrative expenses. The project will begin in Northern Virginia.[125] Other areas may join as the project proceeds and DMAS intends to eventually expand the program statewide.

The state has a contract with Virginia Commonwealth University (VCU) to facilitate DMAS payment for these services. VCU is the contracting entity for the Virginia statewide area health education centers program, one of which (Northern Virginia AHEC, hereinafter AHEC) is participating in the pilot project. In addition to AHEC, three health departments (Alexandria City, Arlington County, and Fairfax County) will provide language services. The three health departments currently offer language services through the use of salaried staff, contracted staff, telephonic resources, and administration of services. AHEC will both provide language services and act as a broker to receive calls from recipients requesting language services; confirm that a covered medical service is involved; and schedule the language services. AHEC will aggregate the claims from itself and the health departments and submit them to DMAS through VCU. AHEC and the three health departments will contribute the state's share of costs and

obtain 50 percent federal reimbursement. This agreement is similar to Washington state's Intergovernmental Transfer (see below).

DMAS will require the participating interpreters and translators to meet proficiency standards, including a minimum 40-hour training for interpreters. The state will reimburse for the reasonable costs incurred by the providers. It anticipates that each health department will have contracts to provide telephonic and/or in-person interpreters; since the health department contracts and language agencies will differ, the state chose not to set a reimbursement rate but rather to monitor spending and evaluate whether a statewide reimbursement rate should be implemented at a later date. There is no formal budget for the pilot project.

Website: **http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/SD222004/$file/SD22.pdf**

Washington

Providers that are not public entities.[126] In 1998, the Department of Social and Health Services' (DSHS) Language Interpreter Services and Translation (LIST) program began contracting with language agencies through a competitive procurement process. Beginning in 2003, the state changed its system to contract with nine regional brokers for administrative scheduling of appointments. The brokers contract with language agencies. In FY 2004,[127] the Department provided interpreters for over 180,000 encounters. Interpreters are paid for a minimum of one hour; mileage is paid if an interpreter has to travel more than 15 miles.

Rather than require clients to schedule interpreters, providers — including fee-for-service providers, managed care organizations, and private hospitals — call a regional broker to arrange for an interpreter. The state requires providers to schedule interpreters to avoid interpreters independently soliciting work and/or acting as advocates rather than interpreters. Once services are provided, the language agency then bills the broker for the services rendered. For interpretation services provided in a health care setting, the claim form requires the name of the referring physician, as well as the diagnosis or nature of illness or injury.

The state pays the brokers an administrative fee; the brokers then pay the language agencies. For Medicaid and SCHIP enrollees, the state obtains federal reimbursement for these costs. Currently, payments to language agencies are $32 per hour. The state spends approximately $978,080 a month on all DSHS language services. The Medicaid portion is currently 79 percent of the total spending but 50 percent of the Medicaid funds are reimbursed by the federal government.

Washington has a comprehensive assessment program for interpreters. The state requires medical interpreter certification for interpreters in the seven most prevalent foreign languages in Washington: Spanish, Vietnamese, Cambodian, Lao, Chinese (both Mandarin and Cantonese), Russian, and Korean. Interpreters for all other languages must be

qualified rather than certified (because of limited resources available for full certification in all languages). The state has given tests for 88 languages plus major dialects and offers statewide testing at five sites, with four days of testing per month per site. Additional tests are available upon request. The state also offers emergency/ provisional certification for those who have passed the written test but await oral testing, and in other limited situations.

Website: **http://www.wa.gov/dshs/list.**

Public hospitals and health departments. Washington has a separate reimbursement program for interpreter services provided at government and public facilities, such as public hospitals or local health jurisdictions. These entities can receive federal reimbursement for expenses related to language services if they enter into a contract (*e.g.* interlocal or intergovernmental agreement) with the state and agree to:

- provide local match funds (locally generated private funds);
- ensure that the local match funds are not also used as matching funds for other federal programs;
- ensure that the local match funds meet federal funding requirements;
- ensure that the local match funds are within the facilities' control;
- use only certified interpreters (as certified by Washington's LIST program);
- coordinate and deliver the interpreter services as specified by the state;
- collect, submit and retain client data as required; and
- accept all disallowances that may occur.

These facilities receive reimbursement for both direct (*e.g.* interpreter services provided as part of the delivery of medical/ covered services) and indirect (*e.g.* time spent coordinating or developing interpreter programs, billing, equipment purchasing) interpreter expenses. The facilities receive reimbursement for 50 percent of their costs — the federal administrative share. Because these entities act as the state for the purposes of reimbursement, the 50 percent state "match" is paid by the facility.

Website: **http://maa.dshs.wa.gov/ InterpreterServices.**

Conclusion

Given the requirements of Title VI of the Civil Rights Act of 1964 that health care providers who receive federal funds ensure access to services for people with limited English proficiency, more states should access available federal funds to ensure that their agencies — and the providers with whom they contract — have the means to hire competent medical interpreters. The use of competent interpreters can improve the quality of care, decrease health care costs by eliminating unnecessary diagnostic testing and medical errors, and enhance patients' understanding of and compliance with treatments.

D

Appendix D. Linguistically Appropriate Access and Services: An Evaluation and Review for Health Care Organizations

Charles C. (Mike) Anderson, M.P.A. Santa Rosa, CA: The National Council on Interpreting in Health Care (2002).

http://www.ncihc.org/NCIHC_PDF/LinguisticallyAppropriateAccessandServicesAnEvaluationandReviewforHealthcareOrganizations.pdf

This tool has a fairly long introductory section followed by a highly detailed assessment form. Excerpts from both are included below.

Excerpts

Why is an Evaluation Process Needed?

Both federal and state laws mandate that health care organizations provide appropriate linguistic access for limited English proficient (LEP) patients. Accreditation agencies such as the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and the National Committee on Quality Assurance (NCQA) set standards and monitor compliance in language services, as in all other areas of operation. What is needed is a nationally uniform approach for health care organizations to guide them in successfully complying with the task set before them. The Office for Civil Rights' Guidance Memorandum on Language Access, most recently released in August of 2000, states that "Recipients (those health care providers who are recipients of federal dollars) are more likely to utilize effective communication if they approach this responsibility on a structural rather than an ad hoc basis." The DHHS Office of Minority Health funded project "CLAS" (Cultural and Linguistic Competence Standards and Research Agenda Project), also published in 2000, recommends that organizations have a "comprehensive management strategy to address culturally and linguistically appropriate services."[128,129,130]

Currently across the United States, the level of preparedness of health care organizations to serve diverse language needs is much more developed in some regions than in others. In some parts of the country with older immigrant populations, such as California and Massachusetts, many institutions took the steps to establish "language services programs" over twenty years ago. In areas with more recently arrived immigrant populations, such as Georgia, the first hospital language services program was not formed until early 2000. The establishment of language services programs in health care organizations is the first step in a complex process of addressing language needs. Such programs can quickly become fragmented and inefficient without a comprehensive organizational plan.

This evaluation tool walks health care organizations through their systems in a way that addresses all points of service, answering to the needs of patients and the organization's staff. It is a comprehensive approach, the development of which draws on the experience and expertise of leaders in the field of medical interpretation. It should be evident that creating a linguistically accessible health care organization requires a review of relevant policies at all levels as well as support from the senior leadership.

This evaluation tool does not dictate how each organization should respond to its patient

population, but rather points to the questions that need to be asked to fully explore, examine and anticipate how the arrival of patient groups of diverse languages and cultures invite a broadening of the concept of patient care. Further, the evaluation tool does not prescribe the "right way" services should be provided; that is left up to the institution. Hopefully a thorough evaluation will lead the institution to develop the best approach for its own unique LEP patient population. The evaluation tool also does not evaluate the wider theme of general cultural competency and cultural awareness training. While the tool does refer to these elements, the proper evaluation is left to a more specialized process. Also, this evaluation does not address other technologies such as video interpreting or electronic translation to provide communication. These areas may need to be added at a later date, as more understanding of their efficacy and cost efficiency is determined.

What are the Expected Outcomes?

It is the intent of the evaluation process to provide hospitals and health care organizations a means to identify:

1. the strengths and limitations of existing linguistic services,
2. risks to the organization,
3. cost drivers,
4. qualitative issues in care delivery,
5. the impact on care outcomes,
6. regulatory compliance issues across ethnic patient populations,
7. a better understanding of ethnic community needs, and
8. internal and external resource availability and allocation.

The list of questions is designed to assure that key parameters are addressed in the evaluation process. It takes into consideration not only the provision of services but also the cost effectiveness and efficiency of service delivery. In today's health care environment, the total cost of providing care is a key element in an organization's ability to provide access to a culturally diverse community.

Parameters and Considerations for Evaluation

The development of the evaluation categories and questions is a synthesis of current thinking about what comprises a competent medical interpreting program. It also draws on work done by such organizations as the DHHS Office of Minority Heath (OMH), the Office for Civil Rights (OCR), the National Health Law Program, the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Quality Improvement System for Managed Care (QISMIC) standards released by HCFA (http://www.hcfa.gov/quality/3a.htm), the Massachusetts Medical Interpreting Association (MMIA) Standards of Practice for Health Care Interpreters (http://www.mmia.org) and others. This evaluation tool however, is not static and will continue to evolve.

The evaluation tool is divided into four major sections that examine the myriad issues in providing comprehensive multilinguistic

services. The questions establish a framework with which to identify both structural and substantive issues in meeting the needs of LEP patients. The framework includes an organizational overview towards services and resources for LEP patients and helps organizations identify the issues involved in the requirements, operation and capabilities of bilingual staff and providers along with face-to-face and telephonic interpreting and translation services. External interpretation agencies, providing both face-to-face and telephonic interpreting services are also incorporated into the evaluation.

Organizational Evaluation Instrument

Organizational Overview

This section is the largest and covers the global approach taken by the organization in addressing the multilingual needs of the patient, including an evaluation of the demographics in the community the institution serves and that of the patient population receiving care within the institution. It further takes into consideration the organization's approach and commitment towards cultural diversity both in terms of organizational structures, as well as the ways in which staff and physicians interact with limited-English-speaking patients on the organizational "front line." By "structures" we mean questions relating to organizational leadership, policies on cultural and linguistic competencies, providers as champions, training, performance appraisals, quality assurance criteria, language tracking of LEP patients/clients, protocols for accessing interpreters, interpreter protocols, hiring and training, and ethno-cultural community involvement.

Bilingually Provided Services

One model of the provision of linguistic access depends on the use of bilingual professionals who provide their particular service directly in the language of the patient. The bilingually provided services section will help shed light on the actual practices of organizational staff members and providers in their interactions with LEP patients/clients. Further, it evaluates how training and testing of language proficiency, if any, is conducted.

Health Care Interpreting Services

Face-to-face Interpreting Evaluation

The predominant way that LEP patients meet their communication needs is through an on-site or face-to-face interpreter. The evaluation process focuses on the quality of the interpretation as well as the attitudes of staff towards interpreters, all of which are key elements in providing an effective

interpreter program. It also looks at the relationship and integration of internal staff interpreters (if available) to those of agency staff that may be utilized. A key issue for organizations is the disparity in the quality of interpretation across various language groups, and how these discrepancies are addressed.

Telephonic Interpreting Evaluation

With the ever-present pressure placed on health care institutions to lower the total cost of care to their patients, there is a movement toward a greater reliance on the use of telephonic technology. Often, telephonic interpreting makes the interpreter more immediately accessible to the provider, particularly in time sensitive situations. In addition, telephonic services can often find interpreters in less common languages. As more institutions look to control their cost of providing interpreting services they are looking at ways to reduce the encounter cost. Telephonic interpreting can help control costs, depending on the per-minute pricing structure. However, little is known about how the shift to a telephonic mode of interpreting may affect the quality of the interpretation, the content of the patient-provider communication, the ability of the patient to navigate the health care system, or patient/provider satisfaction.

How to decide when telephonic or face-to-face interpretation is most appropriate is, at this time, an open question. The evaluation process included here asks questions about the way in which telephonic service is provided, however, how staff utilizes it and under what situations it is limited in scope. The questions asked look at the institution's written policy and procedures to assess if there is any criteria established to provide guidance in determining when telephonic interpreting is used. Further, the evaluation looks at the training and understanding of its use by staff and the level of instruction given the patient who is involved in the interpretation. The tool also directs questions at the level of assessment established to evaluate the training of interpreters used for telephonic interpreting. Whether provided internally or externally assessing training and competency is critical to the successful use of telephonic interpreting.

External Interpreter Agency Evaluation

Most large hospitals and health care organizations today utilize multiple means to meet the growing need for language interpreting. In addition to internal resources, they may include external interpreter agencies, both for-profit and not-for-profit, individually-owned and community-based agencies, to help meet their interpreting and translation needs. External agencies may provide a full-service approach in which all interpreting or translation needs are managed through one or more agencies, or the external agency may function only in a back-up capacity. In any case, there are few institutions that can internally meet the total need for interpreting and translation

services by virtue of the increasing demand for many more languages resulting from changes in immigrant and refugee demographics.

The need to evaluate external interpreter agencies is a critical component in assessing an organization's ability to meet the needs of its LEP patient population. A primary reason for this is the variety in the levels of services and the pool of resources available to meet the demand. Smaller agencies, providing services for a limited number of languages, may not have the resources of mid-size or larger language service agencies to provide the sustained level of testing and training necessary to assure that the interpreter meets the qualifications needed to provide quality interpreting in the medical environment. However, since there are only incipient national standards for medical interpreting, a thorough evaluation of any agency is still needed since the approach and measurement of quality can vary dramatically from agency to agency. In addition, some agencies only specialize in certain areas (e.g. telephonic interpreting), which may limit their ability to comprehensively meet the institution's needs.

While evaluating an external agency's capability it may become apparent that not all of the institutions needs may be met by selected agencies. It is important to work with agencies to foster the quality and service needed by the institution. This will lead to the development of long-term collaborative relationships that are in the best interest of both organizations. Consistency over time is a key component in developing such relationships, leading to higher levels of service and quality in meeting the institutions interpreting needs. This evaluation tool has folding questions about agencies into the sections on face-to-face and telephonic interpreting.

Translation Services Evaluation

Translation of written materials is a vital component in providing LEP Patients access to health care services. Unfortunately, it is often inadequately addressed, particularly for documents such as consent forms, advanced directives, financial materials, and discharge information. In addition, training and education materials commonly provided English-speaking patients are often overlooked. The evaluation tool treats translation in the same context and with the same emphasis as interpreter services, evaluating not only the availability of the material but the process through which new material is identified for translation and made available to patients.

Further, the evaluation looks not only at whether the material is translated, but also the accuracy of the translation. Translation from English to another language is not merely a question of changing from one text to another; it is a very complex process involving consideration of cultural meaning and understanding in a variety of contexts. Assuring accurate translation may involve not just one translation but may in fact require two or three to assure that the proper meaning is conveyed depending on the country and cultural community from which

the patient came. While resources may be limited for translating all materials, a careful evaluation will help an institution determine which documents are most critical to assuring quality of care delivery and will help to determine what alternatives may be available.

In addition, an evaluation of how non-translated material is interpreted and by whom is important. Face-to-face interpreters are often utilized to provide on-site translation of documents, yet may not be qualified as translators, leading to misrepresentation of the printed material. Further, this can add to the cost of the interpreting encounter.

Conclusion

The evaluation tool that follows, then, is designed to help institutions take stock of how well their systems are providing accurate and timely language access services to LEP patient populations. Of course, an evaluation is only the beginning of the process. Once the institution has pinpointed its strengths and weaknesses, a decision must be made about how to improve services in the areas that are weak. This will be the topic of a separate NCIHC Working Paper. For now, we hope that this tool is useful in helping institutions to evaluate their existing language access programs.

Contents of Assessment Form

Excerpts from the Assessment Form

The assessment comprises 154 questions, many of them multi-part. The sampling below should provide an idea of the assessment's nature. The original form contains many more sections and questions than what appears here.

	Yes	No
I. ORGANIZATIONAL OVERVIEW		
Administrative Overview		
1. Is senior management, including the CEO, knowledgeable about cultural and linguistic issues, including the organization's policies and procedures?		
2. Is senior management knowledgeable about the business implications of cultural and linguistic access and services?		
Patient/Member Demographics		
20. Has the organization conducted a demographic analysis of the LEP populations that it serves? - What assessment tools were used?		
21. Are all ethnic and linguistic groups in your catchment area reflected in the profile?		
22. Are there demographic size thresholds for cultural and linguistic communities in your organization's catchment area that determine the organization's activities for providing linguistic services? - If so, explain what they are.		
23. Is each patient's primary language identified? - How and when is this information collected?		
Patient Services		
26. Are interpreters or bilingual providers available during:		
- the admissions process?		
- the enrollment process?		
- financial services?		
- member services?		
- grievance and complaint processes?		
- other non-care patient interactions?		
27. Are interpreters provided at no cost to the patient?		
28. Have there been any grievances filed due to lack of language access? - Please explain the nature and outcome of such grievances.		
29. Have there been any state or federal complaints filed due to language access questions? - Please explain the nature and outcome of such complaints.		
30. Are there records of complaints, grievances etc. specific to language or cultural issues? - Please explain the nature and outcome of such complaints.		
Regulatory Review		
36. Are linguistic services incorporated into accreditation compliance activities? Including the reporting requirements for:		
- NCQA		
- JCAHO		
- QISMIC (HEDIS 3.0)		
- Other (please describe)		

	Yes	No
37. Are patient satisfaction surveys conducted in any language other than English, including the primary languages served by the organization?		
II. BILINGUALLY PROVIDED SERVICES		
Provision of Service		
47. Do bilingual providers and staff utilize their bilingual skills in performance of their routine functions?		
48. What is the profile of bilingual staff? (Create a table by department) -Languages Spoken: Provider Type # of bilinguals Total # Primary Care OB/GYN Mental Health Emergency Medicine		
Policy and Procedures		
52. Are there policies and procedures in place for evaluating individual language skills of providers and staffs? - If so, do they specify when and under what conditions evaluations are conducted?		
53. Are there policy and procedures that specify under what conditions a bilingual provider or staff must use an interpreter in providing care or service?		
III. HEALTH CARE INTERPRETING SERVICES		
Face to Face Interpreting (if none is used, proceed to the next section)		
Overview		
58. Are policy and procedures in place related to the use of face-to-face interpreting? - If so do they specify when and under what conditions this form of interpreting is to be used?		
59. Is the use of an interpreter documented in the patient's medical record? - If yes, what is the frequency of compliance?		
60. Do providers and staff received training on the appropriate use of a face-to-face interpreter?		
61. Is the length of the interpreting encounter recorded? - If so, what is the average length of a face-to-face interpretation?		
62. For what types of encounters is face-to-face (as opposed to telephonic) interpreting utilized? [many examples listed for checking yes or no]		
63. Is there clear documentation to ensure that identified problems are addressed?		
64. Is client data collected in the utilization of face-to-face interpreter services? If so, is it broken down by:		
- Type of encounter		
- Language		
- Duration		
- Time of Day		
- Provider and department		
- Staff		
- Patient ID		
65. Is the interpreter no-show rate recorded? - If so, what is the rate?		
66. What are the driving factors for no shows?		
Bilingual Staff used as Interpreters (*if none are used proceed to the next section*)		
67. Are bilingual staff members used as interpreters?		
68. If staff members are used as interpreters, how does this affect their productivity in their normally assigned work?		
69. Is there qualification in language fluency and health care interpreting that is expected before staff can undertake an assignment?		

	Yes	No
70. Are the following elements assessed and monitored?		
- Understanding of the interpreter's role		
- Adherence to an interpreter code of ethics		
- Accuracy and completeness of the interpretation		
- Use of the first person in interpreting		
- Medical terminology in both languages		
- Grammar		
- Register and mode of interpreting		
- Professional demeanor and comportment		
- Patient satisfaction		
- Provider/staff satisfaction		
73. Is there a continuing education program in place for bilingual staff used to interpret?		
Dedicated Staff Interpreters ***(if none are used proceed to the next section)***		
75. Does your institution hire dedicated staff interpreters?		
76. What languages do your staff interpreters cover?		
77. Is there qualification in language fluency and health care interpreting that is expected of a staff interpreter before hire?		
78. Are the following elements assessed and monitored?		
- Understanding of the interpreter's role		
- Adherence to an interpreter code of ethics		
- Accuracy and completeness of the interpretation		
- Use of the first person in interpreting		
- Medical terminology in both languages		
- Grammar		
- Register and mode of interpreting		
- Professional demeanor and comportment		
- Patient satisfaction		
- Provider/staff satisfaction		
79. Is there organized and on-going recruitment of staff interpreters?		
80. Is there an ongoing training process in place? - If yes, how often is it presented?		
81. Is there a continuing education program in place for staff interpreters?		
82. Does the institution perform an annual review of staff interpreters?		
Agency Interpreters ***(if none are used proceed to the next section)***		
92. Is there a contingency back-up system in place when the agency cannot provide services for a particular language? - If so, explain how arrangements are made.		
93. For which languages can the agency provide service on a regular basis?		
94. How does the agency recruit interpreters?		
95. Is there qualification in language fluency and health care interpreting that is expected of agency interpreters before they are contracted?		
104. Describe how the following elements are monitored by the agency?		
-How is information recorded and authenticated?		
-Adherence to interpreter standards, including confidentiality		

E

Appendix E. Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance

The Interagency Working Group on LEP. C/O Coordination and Review Section, United States Department of Justice, Civil Rights Division, **http://www.lep.gov/selfassesstool.htm**

Outline

Introduction

PART A: SELF-ASSESSMENT

Section I: **Demography:** the number or proportion of LEP persons eligible to be served or likely to be encountered

Section II: **Frequency of Contact:** the frequency with which LEP individuals come in contact with the program and/or activities

Section III: **Importance:** the nature and importance of the program, activity, or service to people's lives

Section IV: **Resources:** the resources available and costs

PART B: DEVELOPING A LANGUAGE ASSISTANCE PLAN

Section I: Goals

Section II: Planning

1. Identification of LEP Persons
2. Language Assistance Measures
3. Training Staff
4. Providing Notice to LEP Persons
5. Monitoring and Updating the LAP

Section III: LAP Evaluation

Excerpts and Sample Sections

This two-part document is intended to assist organizations that receive Federal financial assistance in their strategic planning efforts to ensure that program goals and objectives address meaningful access for all of the people they serve or encounter, including those who are limited-English proficient. First, this tool will assist recipients in assessing their current other-than-English language services capabilities and planning for the provision of language assistance to Limited English proficient (LEP) individuals they serve or encounter. As recipients may be developing performance measures to assist them in evaluating the effectiveness of their program and program delivery, by using this tool, they will be able to assess that effectiveness relative to individuals who are LEP.

The planning and self-assessment questions in Part A of this document are guided by the requirements of Title VI of the Civil Rights Act of 1964, as amended, and Title VI regulations, as set forth in guidance memoranda from the

U.S. Department of Justice (DOJ), Civil Rights Division. (See, e.g., 65 FR 50123 (August 16, 2000), and 67 FR 41466 (June 18, 2002), also available at **http://www.lep.gov**. Part B is intended as a follow-up to Part A, and provides a framework for the development of a Language Assistance Plan (LAP) also in light of general Title VI requirements.

PART A: SELF-ASSESSMENT

The questions in this part are intended for use by Federal recipients in conducting a self-assessment of their progress in providing language assistance to LEP persons. The questionnaire is divided into four sections and is designed to assist in a balanced assessment of the following four factors: (1) Demography — The number or proportion of LEP persons eligible to be served or likely to be encountered; (2) Frequency of Contact — the frequency with which LEP individuals come in contact with the program and/or activities; (3) Importance — the nature and importance of the program, activity, or service to people's lives; and (4) Resources — the resources available and costs.

Section I: Demography

The determination to provide language assistance services should include an assessment of the number or proportion of LEP persons from a particular language group served or encountered in the eligible service population. The greater the number or proportion of LEP persons served or encountered, the more likely language services are needed.

Has your organization developed a demographic profile of the population served or likely to be served by your Federally funded programs and activities?

YES NO

By primary language spoken?

YES NO

If so, list the language groups and the languages spoken.

If not, you can begin your efforts by going to **http://www.lep.gov**.

In addition to the Census and the Department of Education, you can help identify language needs by calling on community-based organizations in your service area.

Is your institution working with any community-based organization(s) that is (are) familiar with the language needs of individuals participating in any of your programs and activities, or to whom you provide services or encounter?

YES NO

If so, describe.

Once your organization has identified general demographic data, which will give you a good overview, you are in a

better position to move to the individual level for those people you serve.

Section II: Frequency of Contact

The following questions are designed to help recipients assess the frequency with which LEP individuals are contacted or encountered and the respective language groups. The more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed. It is also advisable to consider the frequency of different types of language contacts. For example, frequent contacts with Spanish-speaking people who are LEP may require certain assistance in Spanish. Less frequent contact with different language groups may suggest a different and less intensified solution. If a LEP person accesses a program or service on a daily basis, a recipient has greater duties than if the same person's frequency of contact with a recipient's program or activity is unpredictable or infrequent. Notwithstanding, recipients should consider whether appropriate outreach to LEP persons could increase the frequency of contact with LEP language groups.

Does your organization have a process for surveying, collecting and/or recording primary language data for individuals that participate in your programs and activities?

YES NO

If so, describe the categories used in the collection of data, where the data resides, and who can access the data.

Section III: Importance

Once you have assessed what languages to consider with regard to access, both through an analysis of the demography and frequency of contact, you can then look at the nature and importance of your programs, activities, or services.

As a rule of thumb, the more important the activity, information, service, or program, or the greater the possible consequences of the contact to the LEP individuals, the more likely language services are needed. You should then determine whether denial or delay of access to services or information could have serious implications for the LEP individual.

Do you conduct compulsory activities?

YES NO

(For example, do you require applications, consent, interviews, or other activities prior to participation in any of your programs and/or activities, in order to obtain some benefit, service, or information, or in order to participate in a higher level program?) Do you conduct involuntary programs or activities (like custodial interrogations, hearings, trials, evictions, etc.) or provide compulsory education or other mandatory programs or activities?

If so, what are they?

In addition to the above, do you conduct programs or activities that have serious

consequences, either positive or negative, for a person who participates? (including, but not limited to, for example: health, safety, economic, environmental, educational, law enforcement, housing, food, shelter, protection, rehabilitation, discipline, transportation, etc.).

YES NO

What are they?

Have you determined the impact on actual and potential beneficiaries of delays in the provision of services or participation in your programs and/or activities (economic, educational, health, safety, housing, ability to assert rights, transportation costs, etc.)?

YES NO

If so, what are they?

Section IV: Resources

Once you have reviewed your demographics, frequency of contact, and importance of your programs, activities, or services, a good self-assessment will identify the resources (dollars and personnel) available to ensure the provision of language assistance to LEP persons participating in your programs and/or activities. The level of resources and the costs may have an impact on the nature of the language assistance provided. Smaller recipients with more limited budgets are not expected to provide the same level of language services as larger recipients with large budgets. In addition, "reasonable costs" may become "unreasonable" where the costs substantially exceed the benefits.

Reduction of costs for language services can be accomplished by such options as the use of technology (such as sharing through the internet, telephonic language lines, etc.); the sharing of language assistance materials and services among and between recipients, advocacy groups, and Federal grant agencies; and reasonable business practices. You should carefully explore the most cost-effective means of delivering competent and accurate language services before limiting services due to resource concerns.

Have you identified the resources needed to provide meaningful access for LEP persons?

YES NO

Are those resources currently in place?

YES NO

Is there a staff member in your organization assigned to coordinate language access activities?

YES NO

If so, please identify by name or title, etc.

Have you identified the points of contact where a LEP person interacts with your organization?

YES NO

If so, please describe.

Given the identified points of contact, is language assistanceavailable at those points?

YES NO

If so, please describe.

By language spoken, how many employees in your organization fluently speak a language other than English?

What percent of the total employees in your organization are bilingual and able to competently assist LEP persons in the LEP person's language?

Do you utilize employees in your organization as interpreters? (Interpreting is a different skill than being bilingual and able to communicate monolingually in more than one language. Interpretation requires particular skills. For more information, see **www.lep.gov**.)

YES NO

Employees within our organization provide interpreter services (circle one):

- ☐ some of the time.
- ☐ most of the time.
- ☐ always.
- ☐ never.

What are the most common uses by your organization of other than employee (outside sources) language interpreter services?

What outside sources for interpreter services do you use?

- ☐ Contract interpreters
- ☐ Telephone services
- ☐ Community-based organizations
- ☐ Language banks
- ☐ Other (please specify)

For what languages other than English are outside sources of language interpreters most commonly used?

If so, how?

Although you should not plan to rely on an LEP person's friends, family members, or other informal interpreters to provide meaningful access, are there times when you appropriately allow use of such informal interpreters? (See DOJ LEP Guidance from June 18, 2002, **http://www.lep.gov**)

YES NO

If so, under what circumstances?

PART B: DEVELOPING A LANGUAGE ASSISTANCE PLAN

This section is intended to provide a general overview for the development of a Language Assistance Plan (LAP) for LEP beneficiaries or potential beneficiaries. Each Federal recipient may choose to develop an LAP differently. Regardless of the format selected, careful consideration should be given to whether the LAP is sufficiently detailed to address the answers to the questions set forth in Part A, Self-Assessment.

Section I: Goals

After completing the four-factor analysis and deciding what language assistance services are appropriate, a recipient should develop an implementation plan to address the identified needs of the LEP populations they serve. Recipients have considerable flexibility in developing this plan. The development and maintenance of a periodically-updated written LAP for use by recipient employees serving the public will likely be the most appropriate and cost-effective means of documenting compliance and providing a framework for the provision of timely and reasonable language assistance. Moreover, such written plans would likely provide additional benefits to a recipient's managers in the areas of training, administration, planning, and budgeting. These benefits should lead most recipients to document in a written LEP plan their language assistance services, and how staff and LEP persons can access those services. Despite these benefits, certain recipients, such as recipients serving very few LEP persons and recipients with very limited resources, may choose not to develop a written LEP plan. However, the absence of a written LEP plan does not obviate the underlying obligation to ensure meaningful access by LEP persons to a recipient's program or activities. Accordingly, in the event that a recipient elects not to develop a written plan, it should consider alternative ways to articulate in some other reasonable manner a plan for providing meaningful access. Entities having significant contact with LEP persons, such as schools, religious organizations, community groups, and groups working with new immigrants can be very helpful in providing important input into this planning process from the beginning.

Good LAPs should be:

(1) based on sound planning;

(2) adequately supported so that implementation has a realistic chance of success; and,

(3) periodically evaluated and revised, if necessary.

The first topic covered in this part is the establishment of goals in a LAP. The second topic in this part is a brief overview of points that may be considered in developing a comprehensive LAP.

Section II: Planning

Many Federal recipients have found that it is useful, when developing or revising a LAP, to establish a committee or work group that includes administrators, professional and administrative support staff, potential beneficiaries, and members of community

organizations. By working with a diverse group that includes stakeholders, you can receive more comprehensive input from those whose support and efforts may be important to the success of your LAP. Inclusive approaches in plan design and development tend to promote overall community awareness and support. In addition, these individuals will be valuable resources to draw upon during plan evaluation and plan improvement activities.

One of the first things to consider in developing a plan is taking the information you have gained in your self-assessment (Part A), with your goals, and converting it into a viable plan or roadmap that helps your organization identify and address gaps, while at the same time moving toward a coordinated and comprehensive approach to meeting the needs of your organization.

Have you developed a comprehensive plan for language assistance to LEP persons?

YES NO

If not, or if you just want more information to consider in assessing the comprehensiveness of your already existing plan, there are some useful pointers on **http://www.lep.gov**.

Briefly, in designing a comprehensive LAP you should follow the following five steps:

1) Identification of LEP Persons; 2) Language Assistance Measures; 3) Training Staff; 4) Providing Notice to LEP Persons; and, 5) Monitoring and Updating the LAP.

1. Identification of LEP Persons

This first step comprises your consideration of the information obtained from the first two self assessment factors: the number or proportion of LEP individuals eligible to be served or encountered, and the frequency of encounters. This information identifies LEP persons with whom you have contact.

In refining your assessment of your target LEP population, you can use language identification cards (or "I speak cards"), which invite LEP persons to identify their language needs to your staff.

2. Language Assistance Measures

In developing an effective LAP, you should also consider including information about the ways language assistance will be provided. For instance, you may want to include information on:

- Types of language services available
- How staff can obtain those services.
- How to respond to LEP callers.
- How to respond to written communications from LEP persons.
- How to respond to LEP individuals who have in-person contact with your staff.

3. Training Staff

It is essential for the members of your organization to know your organization's obligations to provide meaningful access to information and services for LEP persons. It is, therefore, recommended that your LAP plan include training to ensure that:

- Staff know about LEP policies and procedures.
- Staff having contact with the public (or those in a recipient's custody) are trained to work effectively with in-person and telephone interpreters.

4. Providing Notice to LEP Persons

- Posting signs in intake areas and other entry points.
- Stating in outreach documents (brochures, booklets, outreach and recruitment information) in appropriate languages that language services are available.
- Working with community-based organizations to inform LEP persons of the language assistance available.
- Using a telephone voice mail menu in the most common languages encountered.
- Including notices in local newspapers in languages other then English.
- Providing notices in non-English language radio and television stations about the availability of language assistance services.
- Presentations and/or notices at school and religious organizations.

5. Monitoring and Updating the LAP

One good way to evaluate your LAP is to seek feedback from the community, and assess potential LAP modifications based on:

- Current LEP populations in service area or population encountered or affected.
- Frequency of encounters with LEP language groups.
- Nature and importance of activities to LEP persons.
- Availability of resources, including technological advances, additional resources, and the costs imposed.
- Whether existing assistance is meeting the needs of LEP persons.
- Whether staff knows and understands the LAP and how to implement it.
- Whether identified sources for assistance are still available and viable.

Exemplary practices and further policies with regard to written LAPs can be found at **http://www.lep.gov**. The following questions are designed to assist in assessing your planning needs.

Does your organization have a written policy on the provision of language interpreter and translator services?

YES NO

If so, is a description of this policy made available to the general public?

YES NO

If so, how and when is it made available?

In what languages other than English is it made available?

Do you inform your employees of your policies regarding LEP persons?

YES NO

If so, how?

How often?

Are beneficiaries informed that they will be provided interpreting services at no cost?

YES NO

How are they informed and at what points of contact?

Do you ensure that your translators and/or interpreters are qualified to provide interpreting services (which is a different skill than being bilingual) and understand any confidentiality requirements?

YES NO

If so, how?

Section III: LAP Evaluation

The following information is provided to assist you in identifying methods and approaches for evaluating a LAP. You are encouraged to review your LAP annually and to develop approaches for evaluation that are consistent with your respective LAP designs, individual needs and circumstances. The evaluation process allows for quality feedback into your organization. Also, the evaluation process can be used as a sentinel to detect problems before they grow, and to confirm best practices.

Because Federal law does not prescribe a particular program model or evaluation approach, the approach to, and design of, an effective LAP evaluation will vary for each Federal recipient. The questions set forth below are provided as primers for you to use in developing your own approach.

Do you have and use a tool for collecting data on beneficiary satisfaction with interpreter services?

YES NO

Have any grievances or complaints been filed because of language access problems?

YES NO

If so, with whom?

Do you monitor the system for collecting data on beneficiary satisfaction and/or grievance/complaint filing?

YES NO

Are the data used as part of a review by senior management of the effectiveness of your organization's language assistance program implementation?

YES NO

Do you regularly update your LAP and assess for modifications given changing demographics, or changes or additions to your programs?

YES NO

Do you obtain feedback from the community?

YES NO

Generally, organizations measure "success" in terms of whether a plan, when implemented, leads to the achievement of the particular goals the organization has established. If the organization has established no particular goals, it can still be successful if the results are in concert with the organization's desired outcomes. In this case, the desired outcome is the provision of language assistance, when necessary, in order to ensure that LEP persons are able to participate meaningfully in the Federal recipients programs and activities.

You should modify your LAP if it proves to be unsuccessful after a legitimate trial. As a practical matter, you may not be able to comply with this Title VI requirement unless you periodically evaluate your LAP.

F

Appendix F. Suggested Plan for Implementing Language Services

Suggested Plan for Implementing Language Services[131]

Health care providers can take the following steps to systematically examine their language service needs and how to meet them. Optimally, use of this plan will be supplemented with other resources. These steps are:

Step 1: Designate Responsibility

Step 2: Conduct Ongoing Analysis of Language Needs

Step 3: Identify and Work with Resources in the Community

Step 4: Determine What Language Services will be Provided

Step 5: Determine How to Respond to LEP Clients/Applicants

Step 6: Train Staff

Step 7: Notify LEP Clients of Available Language Services

Step 8: Chart and Update Activities after Periodic Review

Step 1: Designate Responsibility

Deciding how to respond to the community's and client's language needs involves gathering information and investigating and harnessing resources. Providers may want to designate staff members at the headquarters as well as local levels who have responsibility for the language activities. This designation can increase accountability, organization, efficiency, and ready access to community resources and funding.

Step 2: Conduct Ongoing Analysis of Language Needs

According to guidance issued by the U.S. Department of Health and Human Services' Office for Civil Rights, the assessment of language services should balance four factors:

- The number or proportion of LEP persons eligible or likely to be encountered;
- The frequency with which LEP individuals come into contact with the program;
- The nature and importance of the program to people's lives; and
- The resources available and costs.

Often it is not necessary to hire an outside consultant to assess language needs. Rather, a provider can undertake a self-assessment of the languages spoken in the office and in the community. Self-assessment tools are available at no cost. For example, the federal government provides a tool at **www.lep.gov** that, while geared primarily for health care providers, can also be useful for benefits offices. Also, the National Council on Interpreting in Health Care's *Linguistically Appropriate Access and Services: An Evaluation and Review for Health Care Organizations* might be useful despite being developed for health care organizations.[132]

It is important to note that collecting data on a provider's client base may not always provide a complete picture. If a provider has a small number of LEP clients, it may be because there are few LEP clients in the service area, or it could be because LEP clients do not use the office due to a lack of language services. Thus, it is important to assess not only the clients currently being served but also those eligible to be served.

To fully understand the community's language needs, the provider can consult other data. Easily available data sources can provide additional information and include the latest American Community Survey data (available at **http://www.census.gov/acs/www/index.html**), and data from school systems, community organizations, and other agencies/departments of your state and/or county. In addition, community agencies, school systems, religious organizations, legal aid entities, larger health care providers such as hospitals, and other local resources can often assist in identifying populations which may be medically underserved because of existing language barriers.

Finally, it is important to consult and involve the affected community.

Step 2a: Request Clients' Language Needs

The first step in determining which clients need language services is to ask. The provider should also ask for the language needs of the client as well as clients' parents/guardians for children and incapacitated adults. The provider may want to ask not only whether the client needs language services in an oral encounter but also in which language the client prefers to receive written materials and communications. Depending on the language and literacy level of the client, the choice for language services may differ for oral and written communications.

The receptionist and any staff who answer the telephone should request the client's preferred spoken and written language and document it in the client's record and agency databases. This will allow the provider to plan in advance for language needs and maximize appropriate language services during interviews and other client contact.

Providers may want to consider using an "I Speak" poster/card, which allows for identification of language spoken.[133] The provider can provide clients with "Language ID" cards which can be used by the client in direct health care encounters.[134]

Step 2b: Maintain Data on Clients' Language Needs in Databases and Management Information Systems

Providers should document clients' language needs in client case files and databases or other electronic systems. The provider should also document data on the clients' parents or guardians for children or incapacitated adults. Having this information not only will assist in assessing clients' needs but can also assist in arranging for services during appointments. The data will also enable tracking and monitoring of services to LEP clients.

Step 3: Identify and Work with Resources in the Community

As illustrated by the site visit reports, there are a variety of ways to provide language services. Available community resources will help determine what language services to provide and how to provide them. You should examine whether there are local language agencies that can provide in-person or telephonic oral interpretation and/or written translations. You can also contact local immigrant organizations, refugee resettlement programs, or court systems. These organizations are likely sources of information about language services in your community.

National organizations may also be of assistance. The National Council on Interpretation in Health Care offers a variety of resources and also lists local interpreting organizations (**www.ncihc.org**). Other resources include the Society of American Interpreters, the Translators & Interpreters Guild, the American Translators Association, or state-based health care interpreters associations (for example, Alabama, Arizona, California, Colorado, Georgia, Idaho, Kentucky, Massachusetts, Minnesota, Nebraska, New York, Ohio, Pennsylvania, Tennessee, Texas, Virginia and Washington).

Step 4: Determine what Language Services You Will Provide

Depending on your clients' needs, community resources, and your office's resources, you can implement a variety of language services. Your activities will depend heavily on what the self-assessment identifies, and there is no one-size-fits-all solution. As a rough guide:

- In-person face-to-face interpreters provide the best communication for sensitive, technical or long communications.
- Trained bilingual staff — either dedicated full-time interpreters or staff who serve in a dual role (e.g. part-time interpreter and part-time receptionist/billing clerk) can provide consistent client interactions for a large number of clients.
- Contract interpreters can assist with less frequently encountered languages or when the LEP client base is relatively small.
- Telephone interpreter services can often provide an interpreter within 1–2 minutes and are most cost-effective for short conversations or unusual language requests.

Step 4a: Ensuring Competency of Those Providing Language Service

The provider should seek to provide the highest possible level of competency in the types of language services it selects. Competent interpreters can ensure confidentiality, prevent conflicts of interest, and make sure that technical terms are interpreted correctly thus reducing potential errors.

Individuals who are bilingual may not necessarily have sufficient command of both English and the target language. Further, oral interpretation and written translation each require specific skill sets that bilingual individuals may not possess. As stated by the Office for Civil Rights:

> [C]ompetency requires more than self-identification as bilingual. Some bilingual staff and community volunteers, for instance, may be able to communicate effectively in a different language when communicating information directly in that language, but not be competent to interpret in and out of English. Likewise, they may not be able to perform written translations.

There are assessments that can be used to evaluate the language skills of bilingual staff. For example, Pacific Interpreters is available to conduct language competency assessments. And the Industry Collaborative Effort includes an Employee Skills Self-Assessment Test (available at **http://www.healthlaw.org/pubs/nlaap/ICECulturalCompetencies.pdf**). Moreover, if a provider contracts with an outside language agency or interpreters, it should ensure the competency of interpreters, either by requiring a certain level of training and/or conducting a language skills assessment. Similarly, if a telephonic interpreter service is used, the provider should determine what sort of education and training the interpreters have received, whether the interpreters are trained in the necessary terminology and ethics, and whether the company has contracted for alternative site availability in the event their service is unexpectedly interrupted.

Step 4b: Consider Ways to Minimize Use of Family Members or Friends

Significant problems can arise from the use of untrained family members and friends as interpreters. Family members (particularly, minors) or friends who act as interpreters often do not interpret accurately. Untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers. For example, family members and friends often do not understand the need to interpret everything the client says, and may summarize information instead. In some encounters, clients may not disclose sensitive or private information to a child, adult family member or friend who is interpreting.

A provider can adopt a range of language services that minimize the use of family members and friends as interpreters. As the study sites show, resource and cost issues can often be reduced by making use of technological advances (such as the online availability of printed translated materials) and the sharing of language assistance materials

and services among multiple offices. When family members and friends are used to interpret, there can be a follow up visit or telephone contact in the target language to confirm the important aspects of the visit.

Step 5: Determine How to Respond to LEP Clients/Applicants

You will need to determine how to respond to your LEP clients, not only when clients visit the provider but also when individuals call on the telephone (both during and after normal business hours).

Step 5a: Responding In-Person

The first question is how your staff will respond when an LEP client walks into your office. Does your front office staff speak the languages most frequently encountered in your office? If not, how will the front office staff initially communicate with the client? The "I Speak" posters/cards discussed in this report are an excellent first step in responding to clients' needs.

Once the front office staff ascertains the language needs of the client, the staff can make appropriate arrangements for language services. This might include calling a telephone language line so that an interpreter is available during interactions with office staff. It could also include requesting the appropriate bilingual staff to assist the client.

Step 5b: Responding Over the Telephone

The provider should also have a plan for assisting clients over-the-phone during normal business hours. Some questions that should be addressed are:

- Does the office have bilingual staff that can assist LEP clients over the phone?
- Does any "hold message" offer information in the office's prevalent languages?
- If the staff person answering the phone is not bilingual, does this person ask a bilingual staff person for assistance?
- Does the staff person call a telephone language line to assist in communicating with the client?

Step 5c: Responding After Hours

Depending on the scope of your services, after hours communication with clients may occur and communication needs should be addressed in your after hours services. Some of the questions that need to be addressed in the office's language plan include:

- If the provider has an answering machine, does it include messages in the prevalent languages of the client population?
- If the provider uses an answering service, does the service have bilingual employees or a plan to use a telephone language line when an LEP client calls?
- If a client reaches a caseworker or other office staff after hours, what is the plan for that staff person to access language services to ensure effective communication with the client?

Step 6: Train Staff

The provider should consider training its staff on its language plan and policies. At a minimum, staff in direct client contact positions should be trained.

One way to train staff is to ensure that orientation for new employees includes information about your language services. The staff can also attend periodic in-service trainings, staff meetings, or brown bag lunches that reiterate the office's language services, how staff can access these services, and how to evaluate their effectiveness. Sometimes, local community based organizations or interpreter agencies/associations offer training programs focusing on how to work with an interpreter and other relevant topics.

Step 7: Notify LEP Clients of the Available Language Services

It is also important to communicate to the provider's LEP clients about available language services and how to request them. The provider should post information about its language services in the office, translated into the prevalent languages. If the provider disseminates other information, it should consider translating information into the prevalent languages. And if it disseminates any introductory information to new clients, it could have this material translated into its prevalent languages.

The provider could also provide information about its services in local foreign language media. These media are often accessible at no cost as a public service or by participating as a resource. The provider can also disseminate information about its language services through local community based organizations that work with LEP individuals.

Step 8: Chart and Update Activities after Periodic Review

After developing a language services plan, the provider should continually evaluate its effectiveness and update it as needed. As the sites within show, the demographics of a community can shift over a relatively short period of time, necessitating different or additional language services.

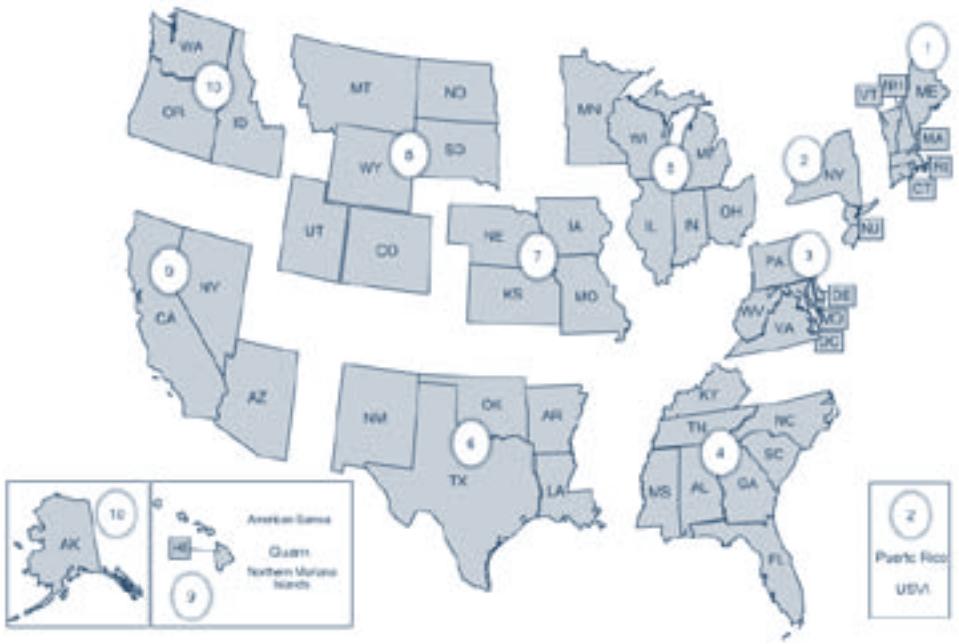
G

Appendix G. Map of U.S. Department of Health and Human Services Regions

U.S. Department of Health and Human Services Regional Map

HHS Regional Offices

Region 1 — Boston
Region 2 — New York
Region 3 — Philadelphia
Region 4 — Atlanta
Region 5 — Chicago
Region 6 — Dallas
Region 7 — Kansas City
Region 8 — Denver
Region 9 — San Francisco
Region 10 — Seattle



H

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65 Fed. Reg. 50121 (Aug. 16, 2001), see also 67 Fed. Reg. 41455 (June 18, 2002).

67 Fed. Reg. 41455 (June 18, 2002).

42 U.S.C. § 2000d.

Endnotes

1 *See, e.g.*, J.A. Crane, *Patient Comprehension of Doctor-Patient Communication on Discharge from the Emergency Department*, 15 J. Emergency Med. 1 (1997) (finding Spanish-speaking patients discharged from ERs less likely than English speakers to understand their diagnoses, prescribed medications, and follow-up instructions).

2 *See, e.g.*, Judith Bernstein et al., *Trained Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-Up*, 4 J. Immig. Health 171 (Oct. 2002) (finding interpreters improved clinic follow-up and reduced post emergency room visits and charges); L.C. Hampers, *Language Barriers and Resources Utilization in a Pediatric Emergency Department*, 103 Pediatrics 1253 (1999) (finding patients with a language barrier had higher charges and longer stays).

3 *See, e.g.*, Michelle M. Doty, The Commonwealth Fund, *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English*, at vii–viii, 8, 11–14, & 21 (Feb. 2003); Dennis P. Andrulis *et al.*, The Access Project, *What a Difference an Interpreter Can Make* 1–2 (Apr. 2002).

4 *See, e.g.*, Barry Newman, *Doctors' Orders Can Get Lost in Translation for Immigrants*, Wall Street J., Jan. 9, 2003.

5 Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health*, at 17 (2002).

6 Glenn Flores *et al., The Importance of Cultural and Linguistic Issues in the Emergency Care of Children*, 18 Ped. Emerg. Care 271 (Aug. 2002).

7 Aaron Manson, *Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma*, 26 Med. Care 1119 (Dec. 1988).

8 Leighton Ku & Alyse Freilich, Urban Institute, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii–iii (Feb. 2001). *See also* Jennifer Cho & Beatriz M. Solis, L.A. Care Health Plan, *Healthy Families Culture & Linguistic Resources Survey: A Physician Perspective on their Diverse Member Population* (Jan. 2001) (51 percent of doctors said their patients do not adhere to treatments because of culture and language barriers).

9 *See* Robin M. Weinick & Nancy A. Krauss, *Racial and Ethnic Differences in Children's Access to Care*, 90 Am. J. Public Health 1771 (Nov. 2000).

10 Sora Tanjasiri, PALS For Health, *Client Evaluation of Interpretation Services* 6 (Apr. 30, 2001).

11 E.J. Perez-Stable *et al., The Effects of Ethnicity and Language on Medical Outcomes of Patients with Hypertension or Diabetes*, 35 Med. Care 1212 (1997).

12 Elizabeth A. Jacobs *et al., Impact of Interpreter Services on Delivery of Health Care to Limited-English Proficient Patients,* 16 J. Gen. Internal Med. 468 (2001).

13 *See* David W. Baker *et al., Use and Effectiveness of Interpreters in an Emergency Department*, 275 JAMA 783–788 (Mar. 13, 1996); Bruce T. Downing, *Quality in Interlingual Provider-Patient Communication and Quality of Care* 7–9 (Sept. 1995) (available from Kaiser Family Foundation Forum, *Responding to Language Barriers to Health Care*) (finding 28% of words incorrectly translated by a son for his Russian-speaking father); Steven Woloshin *et al., Language Barriers in Medicine in the United States*, 273 JAMA 724 (Mar. 1, 1995). The literature thus belies the layman's belief of Dr. Colwell that family members provide the "best translation service." Appellants' Opening Brief at 43, fn. 13. Rather, the research demonstrates that family members not only raise all the problems associated with any untrained "interpreter", but also interject complicated issues of privacy and family dynamics into the equation.

14 *See generally*, J. McQuillan & L.Tse, *Child Language Brokering in Linguistic Minority Communities: Effects on Cultural Interaction, Cognition, and Literacy*, Language and Education 9(3) at 195–215 (1995).

15 *See, e.g.*, David W. Baker et al., *Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-speaking Patients*, 36 Med. Care 1461 (1998); Gold, *Small Voice for Her Immigrant Parents*, L.A. Times, May 24, 1999, at A1; Thomas Ginsberg, *Shouldering a Language Burden*, The Phil. Inquirer, Mar. 3, 2003; Queena Lu, *Children: Voices for Their Parents*, Asian Week, May 17–23, 2001, at 6 (describing a young woman's traumatic experience of telling her mother she had cancer and trying to explain treatment options with her limited vocabulary).

16 Glenn Flores *et al., Errors in Medical Interpretation and Their Potential Consequences in Pediatric Encounters*, 111 Pediatrics 4 (Jan. 2003). Of 165 total errors committed by nonprofessional interpreters, 77 percent had potentially serious clinical consequences. See also, Garret Condon, *Translation Errors Take Toll on Medical Care*, Clev. Plain Dealer, Jan. 20, 2003, at C3.

17 Glenn Flores, Abstract, *Pediatric Research*, April 2003, Volume 53, Number 4. For hospital interpreters with at least 100 hours of training, the rate of errors of potential clinical consequence was only 2 percent.

18 Office of Minority Health, U.S. Dept. of Health and Human Services, *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, Final Report at 73 (March 2001), *available at*: **http://www.omhrc.gov/clas**. The Flores and OMH reports, and the research upon which they are based, thus undermine the Appellant doctors' claim that their "professional judgment" is somehow implicated by a requirement to communicate with LEP patients in a manner that has been demonstrated effective. While such communication may not reflect their personal preferences, they have offered the Court no basis upon which to conclude that evaluating what does and does not constitute effective communication is a matter within the scope of their "professional judgment." They, like the vast majority of us, claim no training in linguistics or interpretation, much less a professional level of expertise in those fields.

19 Office of Management and Budget, *Report to Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons With Limited English Proficiency* 43–52, 55 (Mar. 14, 2002) (based on total and average cost of emergency room, inpatient hospital, outpatient physician and dental visits).

20 Elizabeth Jacobs *et al., Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services*, 16 Supp. J. Gen. Internal Med. 201 (Abstract) (2001).

21 These include "I Speak" cards, examples of which are available at **http://www.lep.gov** and **http://www.palsforhealth.org**.

22 Kaiser Permanente maintains a library of translated clinical materials for its physicians and another of translated non-clinical materials, including consent forms and health education materials. For California's Medicaid and SCHIP programs, L.A. Care Health Plan has translated forms and member materials and is developing a web-based translation service that will identify and translate forms into appropriate threshold languages.

23 *See* Cindy E. Roat, The California Endowment, *How to Choose and Use a Language Agency: A Guide For Health and Social Service Providers Who Wish to Contract With Language Agencies* (2002).

24 *See* Centers for Medicare & Medicaid Services, U.S. Department of Health And Human Services, *Dear State Medicaid Director Letter* (Aug. 31, 2000), *available at* **http://www.cms.hhs.gov/states/letter/smd83100.asp**. To date, thirteen states have chosen cover these costs, either as a covered service or an administrative expense. They are HI, ID, KS, MA, ME, MN, MT, NH, UT, TX (pilot), VA (pilot), VT and WA. See Medicaid/SCHIP Reimbursement Models for Language Services (updated 2005), *available at* **http://www.healthlaw.org/library.cfm?fa=detail&id=71227&appView=folder**.

25 Louis Hampers & J.E. McNulty, *Professional Interpreters and Bilingual Physicians in a Pediatric Emergency Department: Effect on Resource Utilization*, 156 Arch. Pediatrics Adolesc. Med. 1108–1113 (2002); *see also* M.A. Waxman et al., *Are Diagnostic Testing and Admission Rates Higher in Non-English-Speaking Versus English-Speaking Patients in the Emergency Department?,* 36(5) Ann. Emerg. Med. 456–461 (2000).

26 *See, e.g.,* Judith Bernstein *et al. supra, fn.* 13, 4 J. Immig. Health at 174–175 (Oct. 2002); I.S. Watt *et al., The Health Care Experience and Health Behavior of the Chinese: A Survey Based in Hull*, 15 J. Public Health Med. 129 (1993); Sarah A. Fox & J.A. Stein, *The Effect of Physician-Patient Communication on Mammography Utilization by Different Ethnic Groups*, 29 Med. Care 1065 (1991).

27 With permission, excerpted and adapted from The Access Project & The National Health Law Program, Language Services Action Kit, (2002), available at www.healthlaw.org.

28 U.S. Bureau of Census, *2005 American Community Survey, Table B16004 at* **http://factfinder.census.gov**.

29 *Id.* For example, Nevada experienced a 234 percent increase in its LEP population from 1990–2000, ranking third behind Georgia and North Carolina in rate of growth. U.S. Bureau of Census, Census 2000, Tbl. P19, 2000 Summary File (SF 3)-Sample Data, *at* **http://factfinder.census.gov**. (source of 2000 data); Tbl. P028, 1990 Summary Tape File (STF 3)-Sample Data, *at* **http://factfinder.census.gov** (source of 1990 data).

30 U.S. Census Bureau, *Language Spoken at Home for the Population 5 Years and Over, Tbl. B16004*, data from 2005 American Community Survey (hereafter ACS) *at* **http://factfinder.census.gov**.

31 U.S. Census Bureau, *Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over, Tbl. B16004*, data from 2005 ACS *at* **http://factfinder.census.gov**. There is no single way to measure whether a person is limited English proficient. The Census Bureau asks if a person speaks English 1) very well, 2) well, 3) not well, or 4) not at all, and considers only those in categories 3 and 4 to be LEP. However, because medical terminology is often so difficult to understand, many believe that in the health care context anyone who speaks English less than "very well" is LEP. Considering context when determining LEP status is common. See, *e.g.*, in the government's approach to voting rights, where the Department of Justice extends the protections of the Voting Rights Act to persons who are members of a single minority language group, have depressed literacy rates, and do not speak English very well. *See* **http://www.usdoj.gov/crt/voting/sec_203/203_brochure.htm**.

32 See U.S. Bureau of Census, *Ability to Speak English: 2000* (Table QT-P17) *available at* **http://factfinder.census.gov**.

33 U.S. Census Bureau, *Household Language Data by Linguistic Isolation, Tbl. P036*, data from 2003 ACS *at* **http://factfinder.census.gov**.

34 Betsy Guzman, U.S. Department of Commerce Census Bureau, *The Hispanic Population Census 2000 Brief* at 2 (May 2001) (finding from 1990 to 2000, the Hispanic population increased by 57.9 percent, from 22.4 million to 35.3 million, compared with an increase of 13.2 percent for the total population in the United States).

35 U.S. Bureau of the Census, *Language Spoken at Home: 2000* (Table QT-P16), *available at* **http://factfinder.census.gov**.

36 U.S. Bureau of the Census, *Profile of Selected Social Characteristics: 2000* (Table DP-2), *available at* **http://factfinder.census.gov**.

37 *See* Southern California Association of Governments, *The State of the Region 2001* (2001) (on file with National Health Law Program, Los Angeles, CA).

38 *See* Peter T. Kilborn and Lynette Clemetson, *Gains of 90's Did Not Lift All, Census Shows*, New York Times, A20 (June 5, 2002) (finding the immigrant population from 1990–2000 increased 57 percent, surpassing the century's great wave of immigration from 1900–1910 and moving beyond larger coastal cities into the Great Plains, the South and Appalachia).

39 *See* Joel Kotkin, *Immigration Spreads throughout Nation*, WSJ.com Real Estate Journal (undated), *at* **http://www.newgeography.com/WSJ-Reis2.htm**. *See also* North Carolina State Data Center, Office of State Budget, Planning, and Management, *North Carolina Growing Rapidly and Becoming More Diverse* (Mar. 21, 2001), *available at* **http://www.census.state.nc.us.static_cen00_pl_highlights.pdf** (reporting 393.9 percent increase in Hispanic population between 1990 and 2000); Betsy Guzman, U.S. Department of Commerce Census Bureau, *The Hispanic Population Census 2000 Brief* at 5 (May 2001) (reporting that in some counties in North Carolina, Georgia, Iowa, Arkansas, Minnesota, and Nebraska, Hispanics now represent as much as 24.9 percent of the total population).

40 *See* National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, (2003).

41 For examples of these studies, *see Consequences of Poor Communication* in this Toolkit.

42 Sheila Leatherman and Douglas McCarthy, *Quality of Health Care in the United States: A Chartbook* at 122 (Apr. 2002) (available from The Commonwealth Fund) (citing Robert Weech-Maldonado *et al., Racial and Ethnic Difference in Parents' Assessments of Pediatric Care in Medicaid Managed Care*, 36 Health Services Research 575 (July 2001)).

43 *See* Dennis P. Andrulis, Ph.D., Nanette Goodman, M.A., and Carol Pryor, M.P.H., The Access Project, *What a Difference an Interpreter Can Make* (Apr. 2002).

44 Kaiser Family Foundation, *National Survey of Physicians Part I: Doctors on Disparities in Medical Care, Highlights and Charts* 3–4 (Mar. 2002), *available at* **http://www.kff.org/content/2002/20020321a/Physician_SurveyPartl_disparities.pdf**.

45 A number of federal laws have been cited to improve language access, including the civil rights laws, provisions of the Medicare and Medicaid Acts, the Hill-Burton Act, federal categorical grant requirements, the Emergency Medical Treatment and Active Labor Act (EMTALA), and

the United States Constitution. *See, e.g.,* National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, (2003); National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities*, Kaiser Family Foundation (2003).

46 *See* Kenneth E. Thorpe *et al., Medicare+Choice: Who Enrolls? A Study Commissioned by Blue Cross and Blue Shield of America* (Apr. 25, 2002), *available at* **http://bcbshealthissues.com/relatives/19526.pdf**.

47 *See* Centers for Medicare & Medicaid Services, *Medicaid Managed Care State Enrollment* (Dec. 31, 2001), *at* **http://www.cms.gov/medicaid/managedcare/mmcpr01.pdf**.

48 For additional information on Medicaid managed care contract provisions, *see, e.g.,* George Washington University Center for Health Services Research and Policy, *Negotiating the New Health System*, (4th Ed.) (Table 3.6: Translation Services and Cultural Competence), *available at* **http://www.gwu.edu/~chsrp/Fourth_Edition/GSA/Tables/Table3_6.html**.

49 For a complete list of relevant state statutes and regulations, *see* NHeLP, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* (2003).

50 With permission, excerpted and adapted from The Access Project & The National Health Law Program, *Language Services Action Kit*, (2002), *available at* **www.healthlaw.org**.

51 Glenn Flores, *et al., Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, Pediatrics, Vol. 111, No. 1 (January 2003).

52 *See* 65 Fed. Reg. at 52769–80 (August 30, 2000).

53 *See generally*, McQuillan & Tse, *Child Language Brokering in Linguistic Minority Communities: Effects on Cultural Interaction, Cognition, and Literacy*, Language and Education, 9(3) at 195–215 (1995).

54 Roat, Cynthia E. *How to choose and use a language agency: A guide for health and social service providers who wish to contract with language agencies*. Woodland Hills CA: The California Endowment, 2003. **http://www.calendow.org/reference/publications/pdf/cultural/TCE0220-2003_How_To_Choose_.pdf**.

55 In a pre-session, an interpreter and clinician meet briefly before an appointment to establish an understanding of how the encounter should proceed, discuss relevant cultural issues, the health topic or procedure at hand, and/or whatever they believe necessary to prepare for the appointment. There are continuing conversations and strong opinions about some of these issues, pro or con, because of the continuing evolution of this profession.

56 Commonwealth of Massachusetts, Massachusetts Department of Public Health, Executive Office of Health and Human Services, Office of Minority Health. *Best practice recommendations for hospital-based interpreter services, available at* **http://mass.gov/dph/omh/interp/interpreter.htm**.

57 The information in this chapter is adapted with permission from Hablamos Juntos, **www.hablamosjuntos.org**.

58 Reprinted with permission from Hablamos Juntos, **www.hablamosjuntos.org**.

59 All information in this section is drawn from the United States Department of Health and Human Services Office for Civil Rights' web site at **http://www.hhs.gov/ocr/index.html** Washington, DC: U.S. Department of Health & Human Services, 2005.

60 As of 2005.

61 Definitions in this glossary were compiled from the National Council on Interpreting in Health Care, California Healthcare Interpreters Association, Massachusetts Medical Interpreters Association, ASTM International, and the National Health Law Program.

62 Rhode Island Public Law, Chapter 88. **http://www.rilin.state.ri.us**. Passed in 2001.

63 Center for Medicare and Medicaid Services. *Glossary*. 2005. U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services. **http://www.cms.hhs.gov/apps/glossary**.

64 U.S. Department of Health and Human Services, Office for Civil Rights. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. August 16, 2000. 65 Fed. Reg. at 50123.

65 65 Fed. Reg. 50121 (Aug. 16, 2001), see also 67 Fed. Reg. 41455 (June 18, 2002).

66 National Health Law Program. *HIPAA and Language Services in Health Care*. Washington, DC: NHeLP, 2005, *available at* **http://www.healthlaw.org/library.cfm?fa=detail&id=71343&appView=folder**.

67 U.S. Department of Health and Human Services, Office for Civil Rights. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. 68 Fed. Reg. at 47311–47323.

68 CHIA Standards & Certification Committee. *California Standards for healthcare interpreters: Ethical principles, protocols, and guidance on roles & intervention*. Woodland Hills, CA: California Interpreters Association, 2002.

69 National Council on Interpreting in Health Care. *NCIHC National Standards of Practice for Interpreters in Health Care*. [Santa Rosa, CA]: National Council on Interpreting in Health Care, 2005.

70 42 U.S.C. § 2000d.

71 National Council on Interpreting in Health Care. *NCIHC National Standards of Practice for Interpreters in Health Care, available at* **http://www.ncihc.org**.

72 U.S. Bureau of the Census, *Profile of Selected Social Characteristics: 2000* (Table DP-2), *available at* **http://factfinder.census.gov**. See also Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* at 70–71 (2002) (reporting that more than one in four Hispanic individuals in the United States live in language-isolated households where no person over age 14 speaks English "very well," over half of Laotian, Cambodian, and Hmong families are in language isolated households, as well as 26–42 percent of Thai, Chinese, Korean, and Vietnamese).

73 *See* U.S. Bureau of Census, *Ability to Speak English: 2000* (Table QT-P17) *available at* **http://factfinder.census.gov**.

74 *Id*.

75 For example, from 1990–2000, the "top ten" countries of origin of immigrants residing in the United States changed significantly. In 1990, the top ten were Mexico, China, Philippines, Canada, Cuba, Germany, United Kingdom, Italy, Korea and Vietnam. In 2000, while the top three remained the same, three countries fell off the top ten; the remaining changed to India, Cuba, Vietnam, El Salvador, Korea, Dominican Republic and Canada.

76 *See* Peter T. Kilborn and Lynette Clemetson, *Gains of 90's Did Not Lift All, Census Shows*, New York Times, A20 (June 5, 2002) (finding the immigrant population from 1990–2000 increased 57 percent, surpassing the century's great wave of immigration from 1900–1910 and moving beyond larger coastal cities into the Great Plains, the South and Appalachia).

77 1990 and 2000 Decennial Census. Limited English Proficiency refers to people age 5 and above who report speaking English less than "very well."

78 *See, e.g.,* National Center for Education Statistics, *Issue Brief: Adult Participation in English-as-a-Second Language Classes* (May 1998), *citing* Bliss 1990; Chisman 1989; Crandall 1993; U.S. Department of Education 1995; Griffith 1993.

79 Suzanne Sataline, *Immigrants' First Stop: The Line for English Classes*, The Christian Science Monitor (Aug. 27, 2002).

80 *See, e.g.*, Flores G, Barton Laws M, Mayo SJ, et al., *Errors in medical interpretation and their potential clinical consequences in pediatric encounters*, Pediatrics 2003, 111(1):6–14; Ghandi TK, Burstin HR, Cook EF, *et al. Drug complications in outpatients*, Journal of General Internal Medicine 2000, 15:149–154l; Pitkin Derose K, Baker DW, *Limited English proficiency and Latinos' use of physician services*, Medical Care Research and Review 2000, 57(1):76–91. *See also*, Jacobs, et. al., *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature*, The California Endowment (2003), *available at* **http://www.calendow.org/reference/publications/pdf/cultural/TCE0801-2003_Language_Barri.pdf**.

81 *See* Dennis P. Andrulis, Nanette Goodman, and Carol Pryor, *What a Difference an Interpreter Can Make* at 7, The Access Project (Apr. 2002), *available at* **http://www.accessproject.org**.

82 *E.g.* Judith Bernstein *et al., Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up*, J. of Immigrant Health, Vol. 4 No. 4 (October 2002); IS Watt *et al, The health care experience and health behavior of the Chinese: a survey based in Hull*, 15 J. Public Health Med. 129 (1993); Sarah A. Fox and J.A. Stein, *The Effect of Physician-Patient Communication on Mammography Utilization by Different Ethnic Groups*, 29 Med. Care 1065 (1991).

83 Kaiser Commission on Medicaid and the Uninsured, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii–iii (Feb.

2001) (prepared by Leighton Ku and Alyse Freilich, The Urban Institute, Washington, DC). *See also* Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 71–72 (2002) (describing recent survey finding 51 percent of providers believed patients did not adhere to treatment because of culture or language but 56 percent reported no cultural competency training).

84 For the purposes of this document, "providers" includes health care institutions such as hospitals and nursing homes; managed care organizations; insurers; and individual clinicians and practitioners.

85 It is anticipated that this document will be disseminated to other interested stakeholders, Congressional and Administration staff, and the media solely to raise awareness of this issue and to support policies consonant with these principles. However, endorsement of these principles by an organization should not be interpreted as indicating its support for, or opposition to, any particular legislation or administrative proposal that may emerge.

86 As of April 11, 2006.

87 Reprinted from The Access Project & The National Health Law Program, *Language Services Action Kit* (2002), *available at* **www.healthlaw.org**.

88 100 Cong. Rec. 1658 (1964). The United States Supreme Court has treated discrimination based on language as national origin discrimination. See Lau v. Nichols, 414 U.S. 563 (1974).

89 42 U.S.C. § 2000d. *See also* 45 C.F.R. § 80 app. A (listing examples of federal financial assistance, including Medicare, Medicaid, Maternal and Child Health grants).

90 45 C.F.R. § 80.3(b).

91 *See* 42 U.S.C. § 2000d-4a (defining "program or activity").

92 Title VI has traditionally not applied, however, to doctors who only receive federal payments through Medicare Part B.

93 *See* 42 U.S.C. § 2000d-4a.

94 *See* 65 Fed. Reg. 50121 (Aug. 16, 2000), *see also* 67 Fed. Reg. 41455 (June 18, 2002).

95 *See* 65 Fed. Reg. 80865 (Dec. 22, 2000), *available at* **http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3**.

96 *See* 65 Fed. Reg. 50123 (Aug. 16, 2000). In addition to EO 13166, this Guidance is authorized by 28 C.F.R. § 42.404(a), directing agencies to "publish title VI guidelines for each type of program to which they extend financial assistance, where such guidelines would be appropriate to provide detailed information on the requirements of Title VI." According to DOJ, the Guidance does not create new obligations beyond those already mandated by law. *Id.* at 50121-22.

97 *See* 67 Fed. Reg. 41459. "But even recipients that serve LEP person on an unpredictable or infrequent basis should use this balancing analysis to determine what to do if an LEP individual seeks services under the program in question."

98 *Id.* at 50124-25. *See also, e.g.,* 67 Fed. Reg. 41455, 41457 (June 18, 2002).

99 *See* 67 Fed. Reg. 41460 (June 18, 2002).

100 68 Fed. Reg. 47311 (August 8, 2003). To review previous versions of this guidance, *see* 65 Fed. Reg. 52762 (Aug. 30, 2000).

101 Previous guidance cautioned the fund recipient that telephone interpreter lines should not be the sole language assistance option, unless other options were unavailable. *See* 67 Fed. Reg. at 4975.

102 68 Fed. Reg. at 47319-21. Previous guidance called on recipients to develop and implement a language assistance program that addressed: (1) assessment of language needs; (2) development of a comprehensive policy on language access; (3) training of staff; and (4) vigilant monitoring. *See* 67 Fed. Reg. at 4971.

103 The safe harbors designate that the recipient provides written translations of "vital" documents (e.g. intake forms with the potential for important consequences, consent and complaint forms, eligibility and service notices) for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally. Or, if there are fewer than 50 persons in a language group that reaches the five percent trigger, above, the recipient provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of vital written materials, free of cost. 68 Fed. Reg. at 47319.

104 Office of Management and Budget, *Report To Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No.13166: Improving*

Access to Services for Persons with Limited English Proficiency (Mar. 14, 2002), *available at* **http://www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf**.

105 *Id.*

106 *See* CMS, *Dear State Medicaid Director* (Aug. 31, 2000), *available at* **http://www.healthlaw.org/library.cfm?fa=detail&id=71229&appView=folder**.

107 *See* 68 Fed. Reg. at 47313.

108 *Available at* **http://www.healthlaw.org**.

109 This document outlines information gathered as of August 31, 2005.

110 This document is available in the *Language Services Action Kit* from NHeLP and The Access Project at **http://www.healthlaw.org/library.cfm?fa=detail&id=71337&appView=folder**.

111 States can draw down Medicaid/SCHIP funding in two ways — as a "covered service" (paying for the cost of a service, such as a doctor's office visit or a hospital stay) or as an "administrative expense" (paying for the costs of administering the program). For information *see How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and SCHIP Enrollees?* in NHeLP's *Language Services Action Kit, available at* **http://www.healthlaw.org/library.cfm?fa=detail&id=71337&appView=folder**.

112 For "covered services", the federal reimbursement rate varies from 50–83 percent, based on the state's per capita income. For "administrative" expenses, every state receives 50 percent of its costs from the federal government.

113 "Fee-for-service" generally refers to services *not* provided through a managed care organization, community health center or in-patient hospital settings. Providers agree to accept a state-set "fee" for the specific "service" provided.

114 Language agencies are organizations that contract with and schedule interpreters. They may also oversee assessment and/or training.

115 Each hospital or psychiatric facilities' amount is based on a percentage of the difference between the qualifying entity's total Medicaid costs and total Medicaid payments from any source.

116 Providers who have staff interpreters cannot submit for reimbursement.

117 The information from Hawaii is from 2002. The author made repeated attempts to contact Hawaii agency staff to update this information but received no response.

118 FY 2004 ran from July 1, 2003 through June 30, 2004.

119 FY 2004 ran from July 1, 2003 through June 30, 2004. This figure may be low because providers have one year from the date of service to submit claims.

120 The information from Montana is from 2002. The author made repeated attempts to contact Montana agency staff to update this information but received no response.

121 New Hampshire switched from a covered service to an administrative reimbursement due to a change in CMS policy; subsequently CMS clarified that states can get reimbursed at the covered service rate. Since New Hampshire's FMAP for medical services, 50 percent, is the same as for administrative expenses, no practical difference exists in New Hampshire. For SCHIP, considering language services as a covered service would increase the federal share of costs.

122 The state's fiscal year runs from July 1 through June 30.

123 S.B. No. 376 passed the Senate on March 17 and the House on May 9, 2005. A separate bill, H.B. No. 3235, was also enacted requiring provision of interpreter services to deaf and hard of hearing Medicaid patients subject to the availability of funds.

124 For example, pharmacy, dental and chiropractic services.

125 The project will initially include Arlington County, Fairfax County, Falls Church and Alexandria City.

126 Washington has two reimbursement mechanisms. The first is for non-public entities — this includes most fee-for-service providers, managed care providers, and non-public hospitals.

127 The fiscal year runs from July 1, 2003 through June 30, 2004.

128 U.S. Department of Health and Human Services, Office for Civil Rights. Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English. Washington, DC: Federal Register, August 2000. 65 Federal Register. 50123 (Aug. 16, 2000) This version as posted on the OCR website at **www.hhs.gov/ocr/lep/guide.html**.

129 U.S. Department of Health and Human Services, Office for Civil Rights, HHS provides written guidance for health and human services providers to ensure language assistance for persons with limited English skills." Press release, Wednesday, August 30, 2000. Washington, DC: OCR. **www.hhs.gov/ocr/lep/press.html**.

130 *Strategic plan to improve access to HHS programs and activities by limited English proficient (LEP) persons*. Formerly located at **http://www.hhs.gov/gateway/language/languageplan.html** but no longer available there.

131 Excerpted and adapted with permission from National Health Law Program, *Promising Practices for Providing Language Services in State and Local Benefit Offices: Examples from the Field* (The Commonwealth Fund, 2006).

132 This assessment is available at **http://www.ncihc.org**. The tool is very detail oriented, asking over 150 questions, with many subquestions. Most of these questions require a yes or no answer, though a significant number ask for details. It also provides a glossary of terms, a bibliography, and a good deal of explanatory background information and advice on its application in a readable format. Billed as an assessment, it can provide institutions at any level of language services development with many ideas as to what to establish, strive for, or accomplish.

133 For examples of "I Speak" posters, *see* **http://www.dol.gov/oasam/programs/crc/ISpeakCards.pdf and http://www.dhfs.state.wi.us/civilrights/LEPposter.pdf**.

134 For examples of "I Speak" cards, *see* **http://www.palsforhealth.org/**, **http://www.dss.cahwnet.gov/civilrights/ISpeakCard_1304.htm**, **http://edocs2.dhs.state.mn.us/lfserver/Legacy/MS-1857-ENG**, **http://www.dol.gov/oasam/programs/crc/ISpeakCards.pdf**, and **http://www.dhfs.state.wi.us/civilrights/ISPEAKCARDS.pdf**.

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